Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Year Campbell 12 30 2000 6:29p.m. Jeannette 4e Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Randallstown Baltimore Northwest Hospital ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sax Days Months 1 M 2 K F 97 09 28 03 M.D. 212-32-4487 Usual Residenca of Decedent 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location ₩Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Raca - American Indien, 21207 Mountbatten 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes No
If Yes, Give
Yeer or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify 3€Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Caterer Service Caterer 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Loretta Matthews John Coombs 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 21207 Mary B. Jenkins-Daughter 2 Mountbatten Ct, Baltimore Md 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition XXBurial 2 Crametion 3 Removal from State 4 Donetion 5 Other (Specify) Arbutus Memorial Park 1/4/01 Arbutus, 22. Name end Address of Fecility 21. Signeture & Funerel Service Lipense March F/H West 765 Fart1 Entourine disease, or complications that caused the shock, by peart tellure. List only one cause on each limit 4300 Wabash Ave, Baltimore Md death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21215 Approximate the thereof Between Onset end Death Immediate Cause (Final disease or condition resulting in death) · CONGESTIVE HEART FAILURE 15min RTENSION Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequença ot) Dua to (or as a consaquance ot): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case reterred to medical axaminar? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d Describe how injury occurred 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury et Work? 1-Naturel 5 Pending invastigation 1 Yas 2 No 2 Accident

the attending physician and hed for use as the bunal-tran Box 68760, certificate be 1 algned by the Records, been director, page 2 Division of Vitai Physician: After this funeral spital or Attending Parents after death.

neral Director: After filled in by the funer To the Hospital c within 24 hours at To the Funeral D completely filled I

Physician/Medical by Completed Be 10 Certification: edical

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

Examine

Physician

/Medical

Examiner

Funeral

Director

r 28a-t s

d other than 'natural', or herre 23s or event, the Medical Examiner must be r

and Mental Hygi

permit. Pages 1 and 2 at Department of Health and important: if them 27 is in any injury or other traun shide.

Physician

Examiner

/Medical

should be

Maryland 21215-0036

Baltimore.

Directo

Funeral

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29b. Signetura and titla of certifier

6 Could not be

· 23 CAPSSROAD 32. Registrer's Signature

141)

30. Neme and address of person with completed cause of deeth (Item 23e) (Type, Print)

ORIGINAL

28e. Pleca of Injury - At homa, ferm, street, tectory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated.

29c. Licensa number

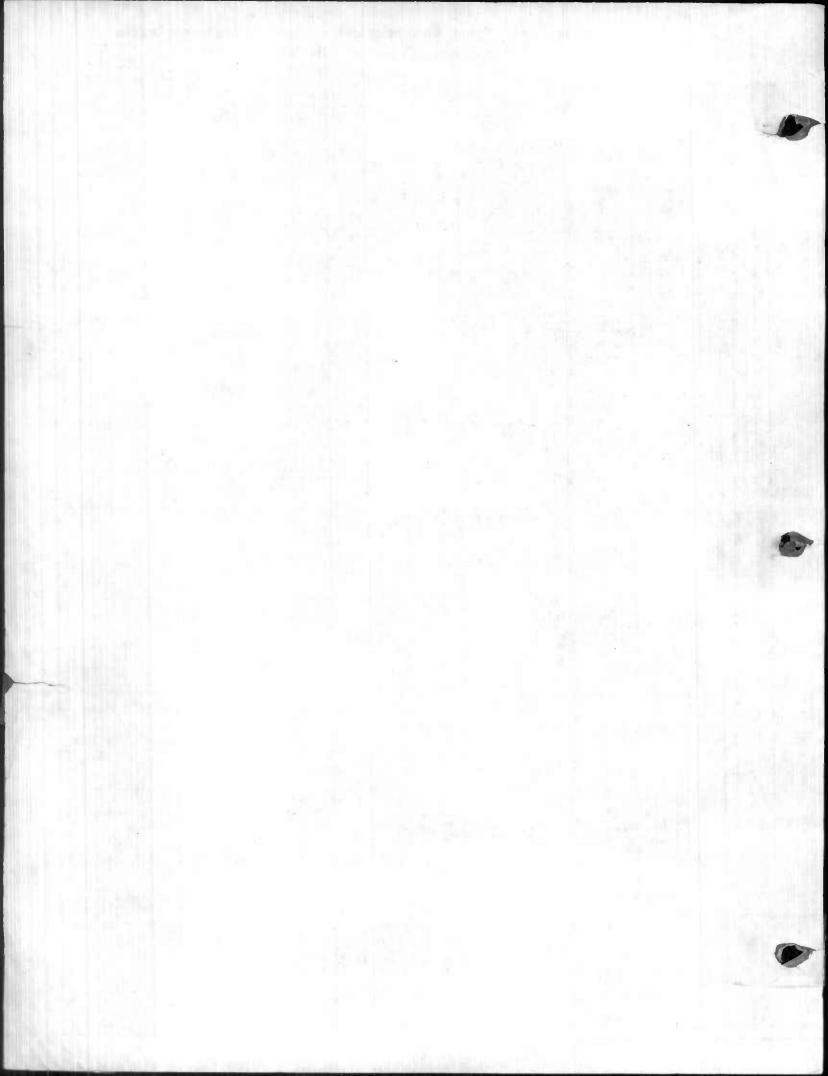
DA

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

#325, OWINGS MILLS

29d. Data signed (Month, Day, Year)

200



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Vaar MARY JANE COMMANDER 2000 18:27 2 26 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore If Under 24 Hrs. If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) June 21, 1 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stete or Foreign Country) Deys Months 1 M 2 F Hours 1914 South Carolina 86 161-20-7934 Usual Residence of Decedan 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2□No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33264 United States P.O. Box 33264 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elamentary/Secondary (0-12) Homemaker Own Home 4 18 Mother's Neme (First Middle Maiden Sumame) 17. Father's Neme (First, Middle, Last) Clara Jackson Warren Moses 19b. Meiling Addrass (Straat end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Raietionship (Type, Print) Nellie Capers (sister) 819 Bonaparte Ave. 21218 Baltimore, Maryland 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete PUBuriel 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 12/31/00 Florence, SC North View Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Sterling ashton Schwab Funeral Home, Inc. 736 Edmondson Ave Balto and 21228 profile a line. 23a. Parti. Enter the shook, or heart fa Approximate Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in death) SEVEN DAYS THE COLON HDEND CAR CINGHA METASTATIC Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in deeth) Last Due to (or es e consequence of) Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were eutopsy findings available prior to completion of cause of daeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Pieca of Deeth (Check only one) Hospitel: Othar: 4 Nursing Home 5 Residence 8 Othar (Specify) 1 Yes 2 No 12 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Deeth Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No NOT APPLICABLE 2 Accidant 281. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be detarmined 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 | Homicida Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and dua to the cause(s) and mennar es steted.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and mennar stated. 29e. Certifier (Check only one)

/Medical Examiner physician the buria certificate be 2 D.0. 2 rigned by Records, certificate has 9090 The Division of Vital Physician: # Attac Attending s after des-al Director: Alt 8 To the Hospital
To the Funeral C

Physician

/Medical

Examiner

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Funeral

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Certification:

Funeral

Director

event, the Medical Examiner must be notified at

death

72 hours after

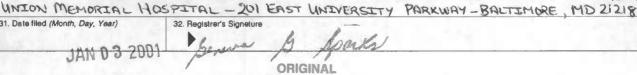
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permit. Pages 1 and 2 should be fit. Department of Health and Mental Hy important: If hem 27 is marked othe any Injury or other treumatic event obtae.

Physician

edical 29b. Signature and title of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) AL HDDASI, MD - DEPARTMENT OF SURGERY 31. Date filed (Month, Day, Year) State

Phodan



SURGICAL RESIDENT

29c. License number

AT-2438946-P41

29d. Date signed (Month, Day, Year)

DECEMBER 26th

Registrar **DHMH 16 Rev 6/95**

THE CO. LEWIS CO. LEWIS CO., LAND CO

Piease Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Day Yee Physician 12:00 Pm Mattie Clay 12 30 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blue Point Nursing Home Baltimore If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar Birthplaca (State or Foreign Country) **Funeral** Months Days 1 □ M 2X0 F 91 Yrs. Director 347-26-4486 May 22,1909 Mississippi Usual Rasidenca of Decedant the Maryland 10h Count 10c. City, Town or Location 10e State 10d. Inside City Limits "natural", or frams 23a or 28a-f show addes Examiner must be notified at Yas 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? death with 3806 Callaway Avenue 21215 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forcas?

1 ☐ Yas 2 ☒No
If Yas, Give
Yeer or Detas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien. 11 Merital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Exercises once. Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married Baitimore, Maryland 21215-0036 1 ☐ Yas 2 No Specify: Specify: BLACK þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) Elamentary/Secondery (0-12) College (1-4or 5+) 6th Cook Private Families 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Tom Brown Nannie Matthews 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Viola Brown-Sister-In-Law 3806 Callaway Ave. Balto. MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ₽ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Pk. Cem.01/03 Baltimore, MD 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licansee Nutter Funeral Home Inc. nutter 2501 Gwynns Falls Pkwy Balto. MD 21216 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Finel diseesa or condition rasulting in daath) Murum Examiner Dua to (or as a consaguanca of) Examiner physician and the bunei-transit The law requires that the death certificate be asscuted Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): 50 attending p for use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown by 24b. Ware autopsy findings eveilable prior to completion of cause of daath? been si 24a. Was an autopsy performed? Completed is certificate has b 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No Physician: 25. Wes casa refarred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Rasidenca 6 Othar (Specify) 10 Aftar this 28a. Data of Injury (Month, Day Year) 27. Mennar of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Patter death. 1 Naturat 5 Pending invastigation 1 Yas 2 No actor: by the 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Ptace of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and dua to the causa(s) end manner es stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) W 1/2/01

State Registrar 21208

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

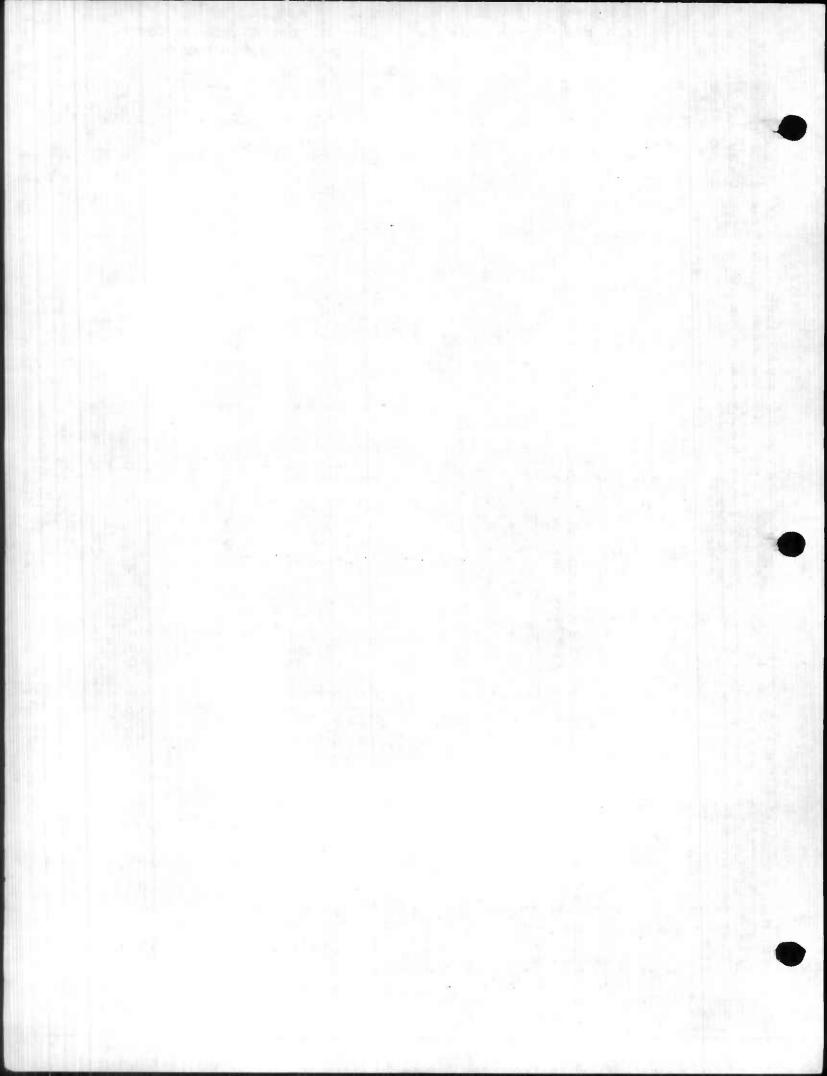
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JAN D3

31. Data filed (Month, Day, Year)

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32. Registrar's Signatura



Funeral

Director

d 2 should be filled within 72 hours after death with the Marylen th and Mental Hyglene.
7 le merked other than "naturel", or items 23a or 28a-f ahow treumstic event, the Medical Francher, man be notified.

permit. Pagea 1 and 2 should be file Department of Health and Mental Hy Important: If fem 27 is marked othe eny injury or other treumstic event, pages.

Physician

/Medical Examiner

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his certificate has but director, page 2 st

this funeral

After Attending

death.

To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: Al Completely filled in by the fu

law requires that the death certificate be executed

P.

Physician:

Box 68760.

Division of VItai Records,

Baitimore, Maryland 21215-0036

Marylend

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Dav Year Month Physician Bessie Lee Chavis 27, 2000 December 2024 pm /Medical 4e Facility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examine Johns Hopkins Hospital Baltimore Hours Min. 8. Data of Birth (Month, Day, Year) 09/04/1933 If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 67 241-52-0191 North Carolina Usual Residence of Decedant 10d. Inside City Limits 10e. Stata 10b. County 10c. City. Town or Location 1 Yes 2 No Maryland Directo N/A Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 31 South Ann Street 21231 LISA 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva 11. Marital Status 1 Nevar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: American Indian by 3 Widowed 4 Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Welder Factory 17 Fether's Nama /First Middle (ast) 18. Mothar's Nama (First, Middle, Maiden Surnama) John Leach Locklear Roberta Chance 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Raletionship (Type, Print) Regina Baldwin / Daughter 16 Foxhound Ct. Randallstown, Maryland 21133 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata Oak Lawn Cemetery 12/30/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility David J. Weber Funeral Homes, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

Approximate

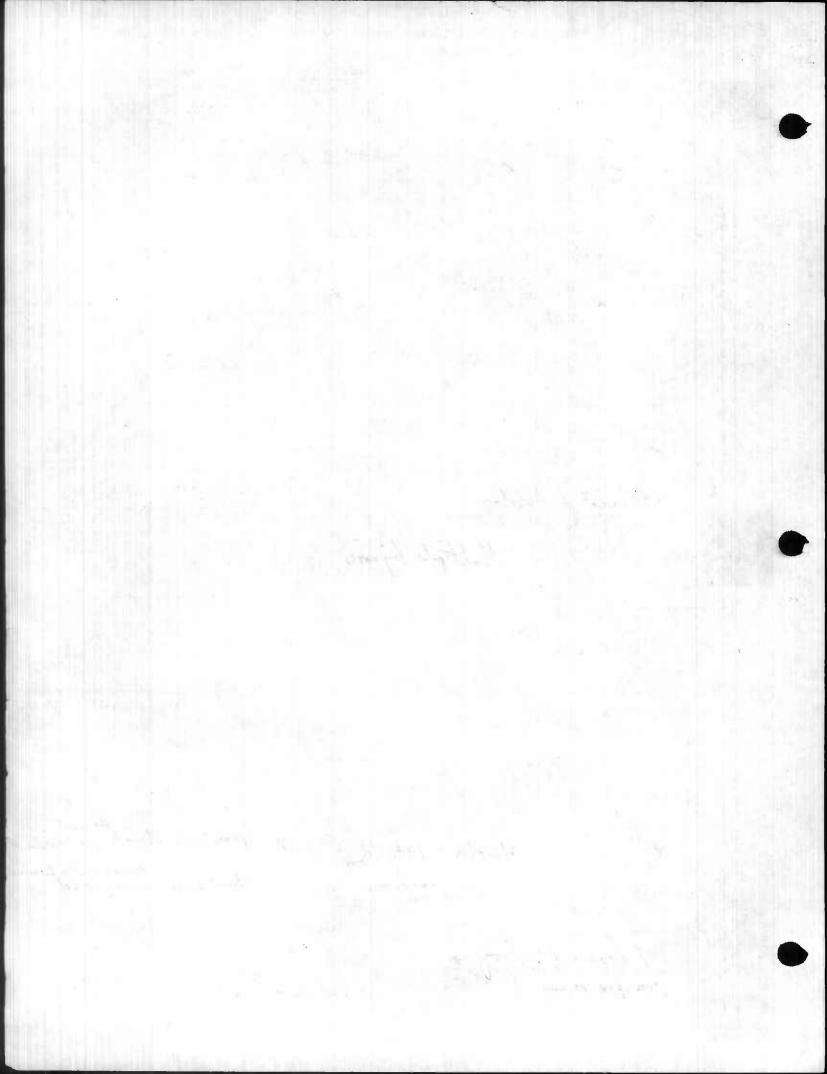
Approximate Approximata Intarval Between Onset end Death Immediate Causa (Final disaasa or condition rasulting in death) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Lest Due to (or as a consequence of) Physician/Medical Dua to (or as a consequence ot): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? Yas 2 No 25. Was casa ratarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 2 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28d. Dascribe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day 28b. Tima of 28c. Injury at Work? Certification: 1 Natural 5 Panding investigation K by which 1 Yes 2 No 2 Accidant 3 ☐ Suicide 127 S 6 ☐ Could not be Placa of Injury - At homa, farm, streat, tactory, office building, atc. (Specify) Location (Street and Number or Ryral Route Number City or Town, Stata) Ann Street 4 Homicida | Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licanse number O.C.M.E. December 28, 2000 secodie (m) 30. Name and address of person who complated cause of death (Itam 23a) (Type, Print) THEUDONE M. KM 111 Penn Street, Baltimore, Maryland 21201 31. Data tiled (Month, Day, Year) 32. Registrer's Signeture

ORIGINAL

State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** KNEKSE 2000 15 am 1)0 /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) are Saltimo68 Charlestown enter If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 25 F 486-09-0560 Yes 84 Director 01/13/1916 KANSAS Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral', or itema 23a or 28a-f shore 1 ☐ Yas 2 No MD BALTIMORE Director CATONSVILLE 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? with 709 MAIDEN CHOICE LANE 21228 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 72 hours aftar 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married natural', or 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grede completed) 16b. Kind of Business/Industry with and Mental Hygiene.
27 Is marked other than "r r treumatic svent, the Mental of t Elementery/Secondary (0-12) 1 2 College (1-4or 5+) SOCIAL SECURITY CLAIMS ADJUSTER Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pagas 1 and 2 should be fill ment of Haaith and Mental Hant: If Item 27 is marked oth jury or other treumatic even Be PATRICK WATERS LENA WINKLER 19e. Informent's Name/Reletionship (Type, Print) 19h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE B. CAVANAGH (SON) 769 BRUSHWOOD CT. MILLERSVILLE, MD. 21108. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Important: If It any Injury or c once. 1 Burial 2 Crametion 3 Ramoval from Stata **Department** NEW CATHEDRAL CEMETERY12/30/2000 BALTO., MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21 all III 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset end Deeth **Physician** EUR home Obstrative /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Minary du East Examiner Examine Sequentielly list conditions, if eny, leading to immadiete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, P. à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed erneese 1 Yes 20 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA to 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Affer Division 1 Neturel 5 Pending 1 Yes 2 No Invastigation 2 Accident after deat Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 9 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and plece, end due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29b. Signature end title of certifian 29d. Data signed (Month, Day, Year) where U

State Registrar

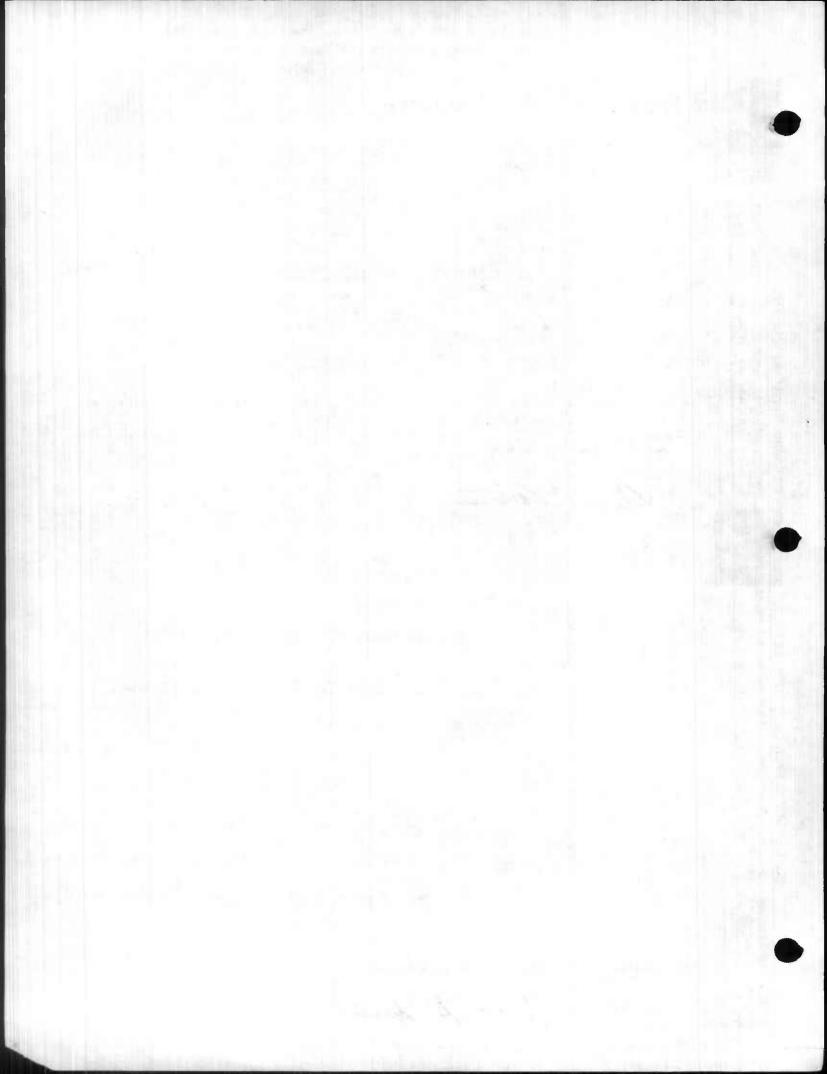
DHMH 16 Rev 6/95

Maiden choid lane, catonville, MD, 21228

end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

th Day Year



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ANNETTE M.	CORKRAN	State of Maryland / Department of Health and Mental Hygiene 0 20

10c. City. Town or Location

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tate of Maryland / Department of Health and Mental	Hygiene	n	42	1	1	6
Certificate of Death	Per No	0	T ba	. 0		

PARKVILLE

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	Physician /Medical	A
	Evaminer	4e Fac

edent's Neme (First, Middle, Last) NNETTE MARIE CORKRAN ility Neme (If not Institution, give street and number)

Month: 4b. City, Town, or Location of Deeth

DECEMBER 4c. County of Deeth

2. Dete of Death

3. Time of Death Year 26 2000 01151

Funeral

the Maryland

72 hours after

Maryland 21215-0036

Baltimore,

Physician

/Medical

Examiner

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To the P

Records, P.O. Box 68760,

Division of Vital

Examiner

Physician/Medical

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Certification:

Director ral', or Items 23a or 28a-f ahow Examiner must be notified at D Funerai "natural", or P er then "neturn Completed permit. Peges 1 and 2 should be filed within 72 l Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natu any injury or other traumatic event, in a limited pings.

Be

8612 OUENTIAN AVE 5. Sociel Security Number 6. Sex 212-30-6885

10b. County

BALTIMORE

7. Age (In vrs. last birthdev) 1 M 2 F 65

If Under 1 Yeer If Under 24 Hrs. Days Min. Months Hours

9. Birthplece (Steta or Foreign 8. Dete of Birth (Month, Day, Year) MARYLAND

Dey

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

Usual Residence of Decedent

10e. Stete

PARKVILLE 10f. Zip Code

21234

10g. Citizen of What Country? USA

BALTIMORE

8612 QUENTIN AVENUE

1 Never Merried 2 Married 3€ Widowed 4 Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 ☐ Yes 2 No Specify.

14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elemantary/Secondary (0-12) 11TH GRADE

HOMEMAKER

METRO CREMATORY, INC.

OWN HOME

17. Fether's Neme (First, Middle, Last)

GEORGE J. ALBAN

18. Mother's Nama (First, Middle, Maiden Sumeme)

EMMA FOLEY

19e. Informant's Neme/Reletionship (Type, Print)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) 9628 DUNDAWAN ROAD DAUGHTER

BRIDGET M. COLCLOUGH 20e. Method of Disposition

20b. Plece of Disposition (Name of cemetary, cremetory or other plece) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete

PERRY HALL, MD Date

20c. Location - City or Town, Stete 12/28/00 CATONSVILLE, MD

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service License

22. Name end Address of Fecility THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD

dena

inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, in heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Death

21286

Immediete Cause (Final diseese or condition resulting in deeth)

Sequantially list conditions, if any, leading to immediate ceusa. Entar Undarlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or es e consequence of)

Due to (or es e consaquence of):

Due to (or es e consaguence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown

SCHIZOPHRENIA

24e. Wes en eutopsy performed?

1 Yes 2 No

24b. Were eutopsy findings available prior to complation of ceuse of death?

INSPECTION

28d. Describe how injury occurred

1 Yes 2 No

at scene

25. Wes case referred to medical Yes 2 No

27. Manner of Death 1 Natural 2 Accidant

3 ☐ Suicide

29a. Certifier

4 Homicida

5 Pending investigation 6 Could not be detarmined

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Dete of Injury (Month, Dey Year)

28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Othar (Specify)

26. Plece of Deeth (Check only ona)

281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and mannar as stated.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, and due to the ceuse(s) and mannar stated. (Check only one) 29b. Signeture end title of certifier

MID.

29c. License number O.C.M.E

29d. Dete signed (Month, Dey, Year) DECEMBER 27,2000

of deeth (Item 23a) (Type, Print) 30. Neme and addre who completed ceu;

31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

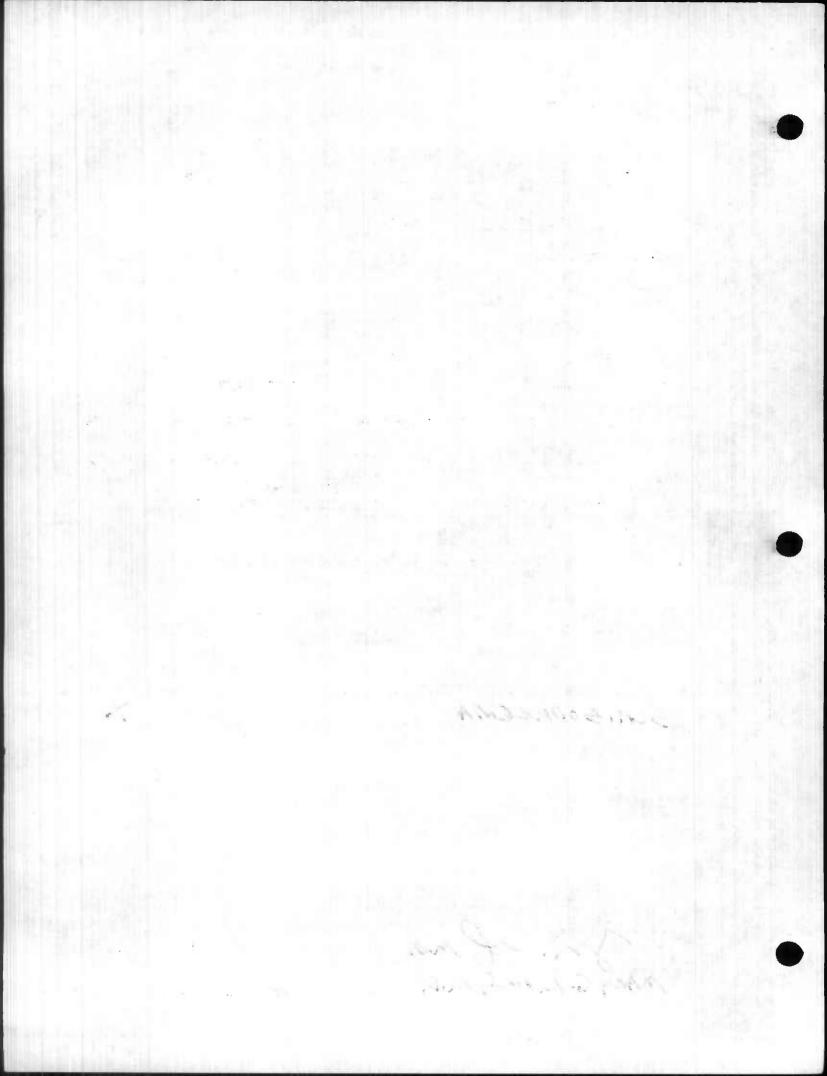
111 Penn Street, Baltimore, Maryland 21201

State Registrar

03

ORIGINAL

DHMH 16 Rev 6/95



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Am	ended Item#	9 perFHG791 1/9/2001 EW		Ce	rtificate of	Death	Re	g. No.	46	001	
	P	1. Decedent's Neme (First, Middle, Last)				2. Deta of Death Month	Dey	Year	3. Tima of Death	
	Physician /Medical	Howard Ellis	Dawson				Decembe	r 29, 2	2000	3:55AM	
	Examiner	4a Facility Nama (If not institution, giva street and number)				4b. City, Town, or I	ocation of Death	ath 4c. County of Deeth			
		Gilchrist Center				Towson	1	Ba	ltimor	:e	
	Funeral Director	218-34-2008		rs. lest birthday, 3 Yrs.	Months Deys		8. Data of Birth (Month, Day, July 10	Year) ,1937	9. Birthple Country Mary	ce (Stete or Foreign	
	D Res	Usuel Residance of Decedent 10a. Stete 10b. County	10c.	City, Town or L	ocation				100	d. fnside City Limits	
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	or 28a-f s be notified Director	10e. Street and Number		7	10f. Zip Code		10	g. Citizen of \	Whet Country	y?	
	n with	19039 Graystone R	oad		2	21161			USA		
	ther death v r thems 23a plost must Funeral	11. Maritel Stetus	12. Was Decedent Ever in Armed Forces?	1 U,S. 13.	Wes Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No-		ca - American		
980	be filed within 72 hours after death with the Maryla be filed within 72 hours after death with the Maryla dether than "naturals, or flame 23a or 28a f ahor event, the Medical Examinat must be notified at Be Completed by Funeral Director	1 ☐ Naver Marriad 2 ☐ Married 3 ☐ Widowed 4 🖔 Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:		1□ Yas 2Ā No		o modifi, ato.)		Whit		
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21		Elementery/Secondary (0-12)			e during most of wor ed)	9					
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Baltimore,	Pages ient of nt: # lb	1 ☐ Buriel 2 X Cremetion 3 ☐ F	Removel from State B		metory or other pl e Washin Y		Dec. 30				
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Ba	Depart Depart Import any in	21. Signeture of Funeral Service Itemsee 22. Name end Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093									
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4	nificate be execut ng physician and as the burial-tra- Medical Exan	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		(0.000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
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Box			d	-					1		
	sicial	Pert II. Other significant conditions cor	ntributing to death but not	resulting in the	underlying cause g	iven in Pert I.	23b. Did tobacco use contribute to the cause of death				
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5	After funer funer floor:	27. Menner of Deeth 1 ØNetural 5 ☐ Pending	28a. Dete of tnjury (Month, Dey Year	28b. Time of tnjury	W		28d. Describe ho	w injury occui	rred		
S		2 Accident investigation 3 Suicide 6 Could not be]Yes 2□No	28f. Location (St	and Alumi	har or Pural	Poute Number				
Division of	Direct In by	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	reet, ractory, onice		City or Town	Stete)	or or rigion	710010 11011007,	
-	2.3 FE =	29e. Certifier To Certifying Physicians (Check only one) 2 Medical Exami	sician: To the best of my liner: On the basis of exem	knowledge, deel	th occurred at the nvestigetion, in my	time, date end plece opinion, deeth occu	, end due to the ca cred et the time, de	use(s) end m ite end plece,	enner es sta end due to t	ited. the ceuse(s)	
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State Registrar

Helen M. Gordon MD 6601 N. Charles St Baltimore MD 31. Date filed (Month, Dey, Year) 32. Registrar's Signatura

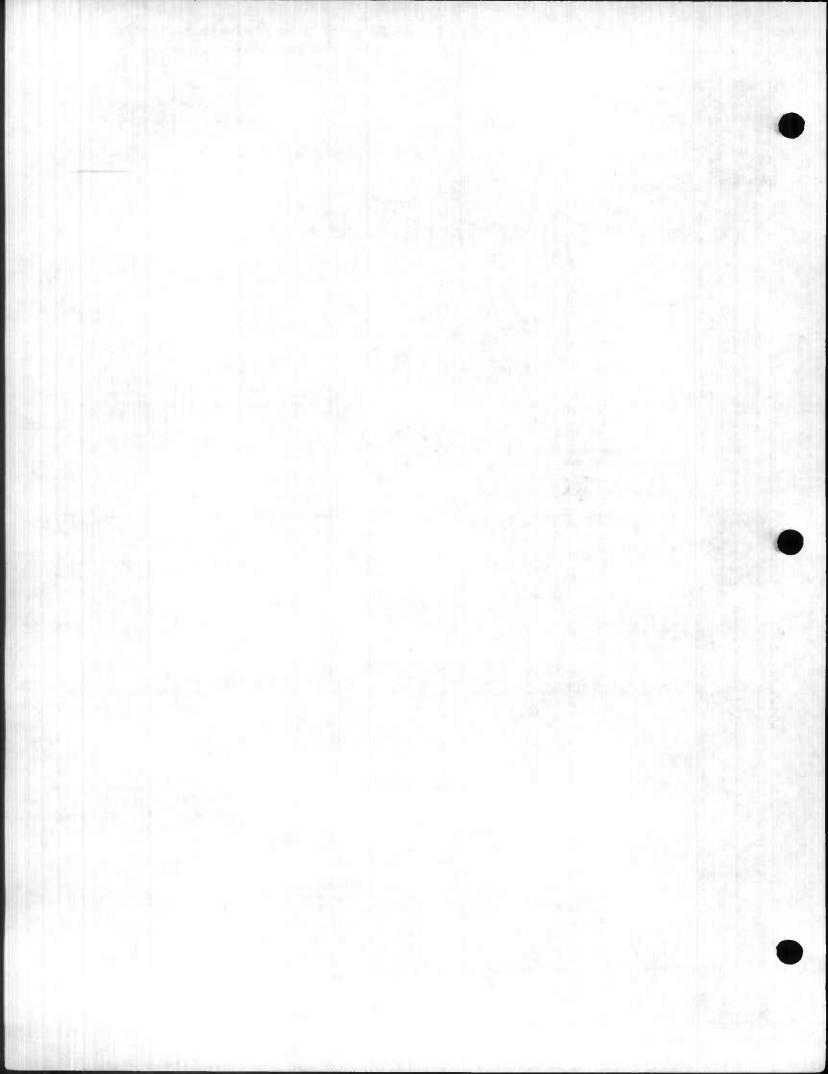
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JAN

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12/29/300 @ 3:55 Mm

Mr. H. E. Wis Dawson



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42008 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **ELEANOR** DUGAN December 30,2000 8:10PM DENISON 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore If Under 24 Hrs. 8. Data of Birth (Month, Day, Yea If Under 1 Year Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1□ M 2□ F Yrs. 84 March 6,1916 MAryland 215-10-6030 **Usual Residence of Decedent** 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas ANO Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8800 Walther Blvd USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Vas 2 □ No WW I If Yes, Give Year or Datas: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc WWII 1 Never Married 2 Married 1 Yas 2 No Specify: White Specify: X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Ferdinand Chatard Dugan Melanie Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca D. Baummer DTR 325 Dixie Drive Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1XX Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) New Cathedral Cemetery 1/3/01 Baltimore, Maryland 22. Nama and Addrass of Facility uniture of Funeral Service Licenses Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 M 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Daath tmmediata Cause (Final neumonia disease or condition resulting in death) Vascular Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Tunknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 25. Was cese referred to medicat axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: Tursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours effer. Hyglene. Ither than "natural", or ite

i. Pages 1 and 2 should be filled will thent of Heelth and Mental Hyglen tamt: if Item 27 is marked other the lury or other treumatic event, the

permit. Page Department of Important: If eny injury or page.

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

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ettending physicien end for use as the buriel-transit Box 68760, ed by the detached Division of Vital Records, P.O. signed by t peen or Attending Physicien: diractor. this side

Examiner Physician/Medical À Completed 8 Certification: To After thi deeth.

To the Hospital or Attendition within 24 hours effer deeth.

To the Funeral Director: A completely filled in by the fu edical

State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year).

5 Pending investigation

6 ☐ Could not be

Natural

2 Accident

3 Suicide

29a. Certified

4 ☐ Homicide

(Check only one)

29b. Signature and title of certified

einer mo, 32. Registrar's Signatura

and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

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- Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated.

29c. License number

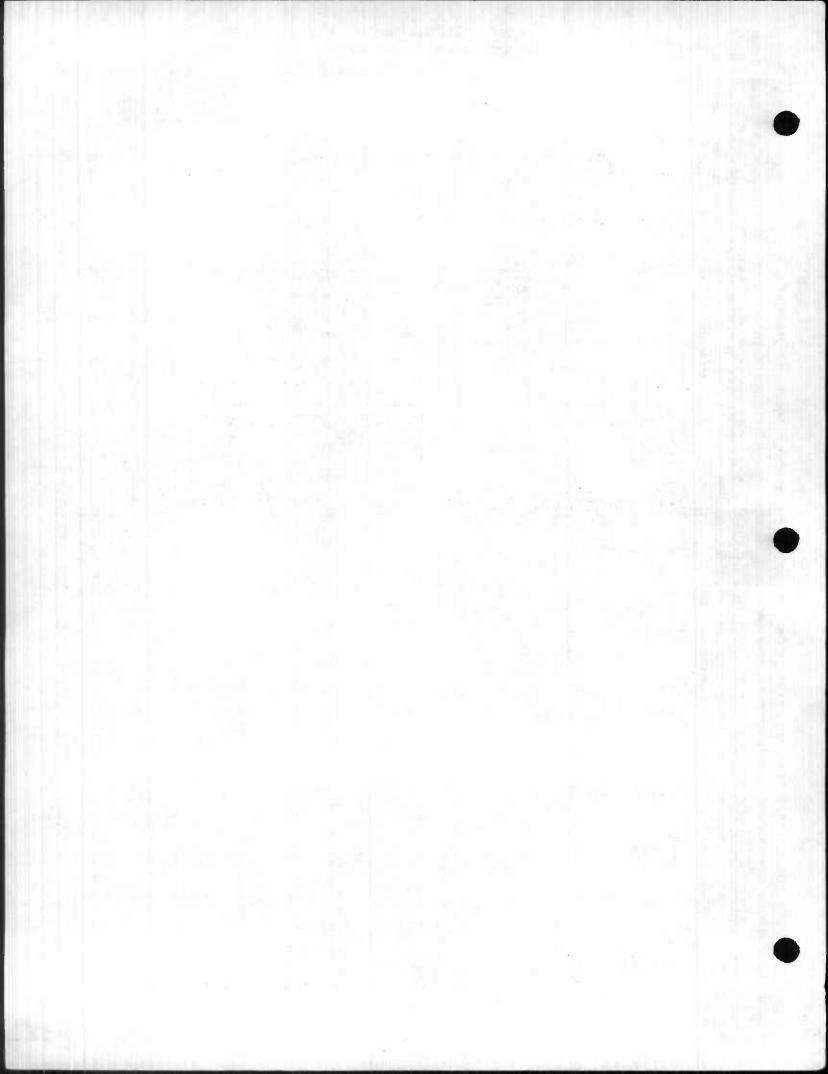
1 Yas 2 No

niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

281. Location (Street and Number or Rural Route Number, City or Town, State)

Blvo Parkvile, Md 21234

29d. Data signed (Month, Day, Year) Jon, 2, 2001



Registrar

DHMH 16 Rev 6/95

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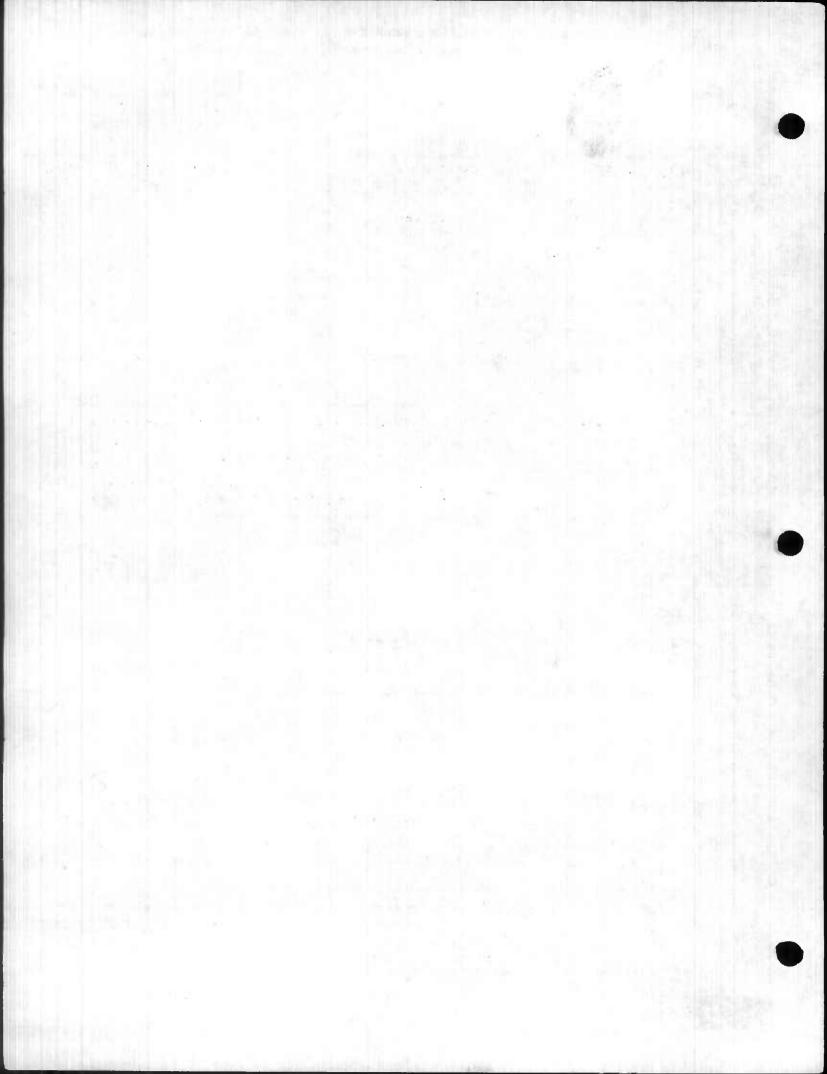
32. Registrar's Signature Penn Street, Baltimore, Maryland 21201

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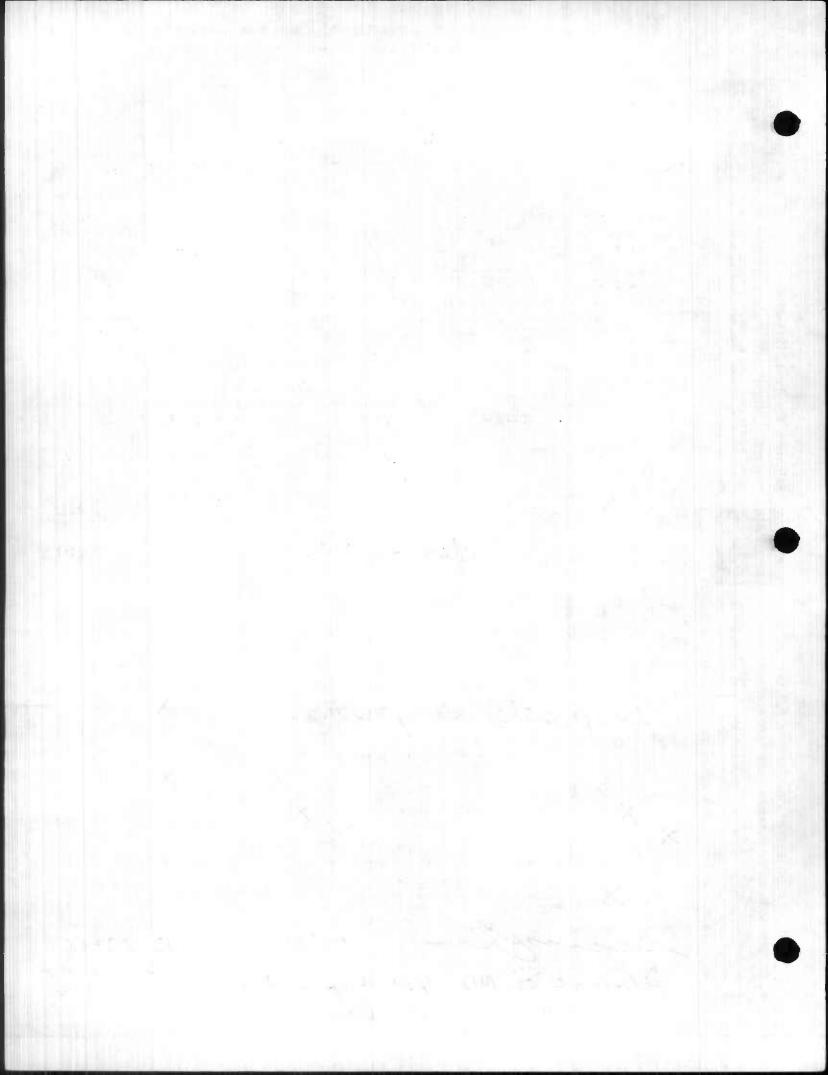
31. Date filed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene

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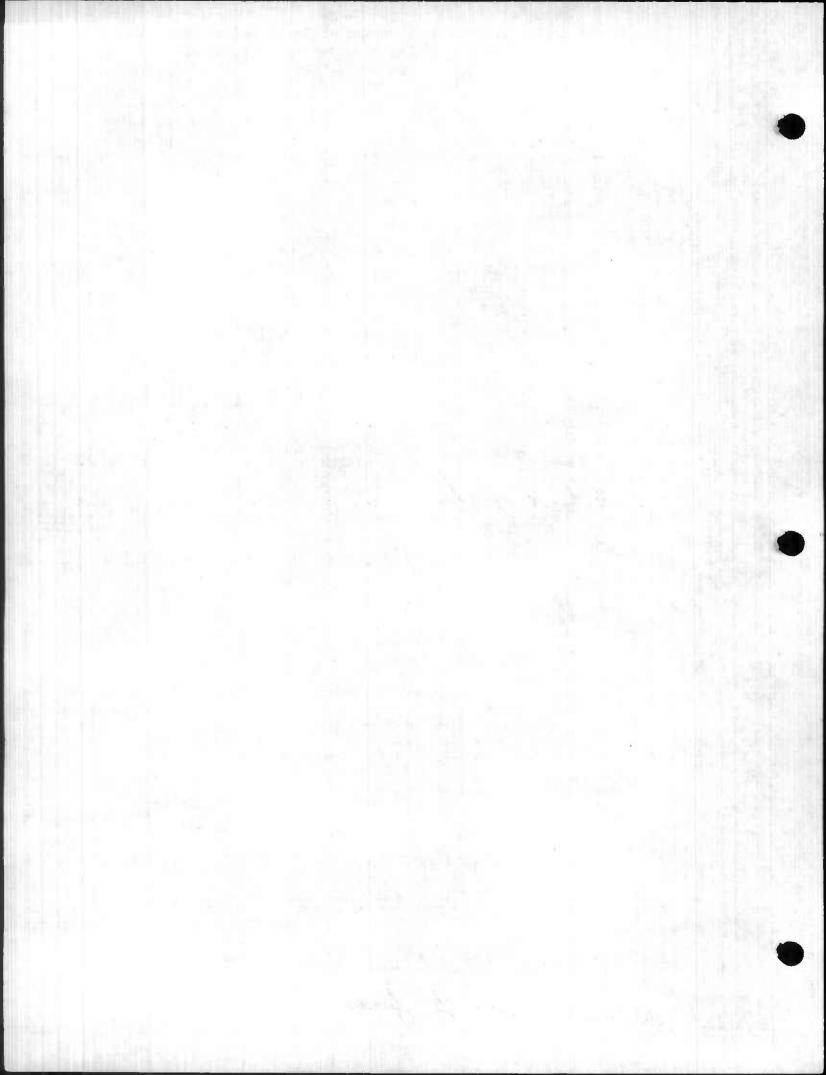


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Helen Edgar Edwards 8:20 a.m. December 30, 2000 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Colonial Manor Nursing Home Odenton Anne Arundel 5. Social Security Number 6. Sax If Under 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Months 1 □ M 2XX Days Hours Min Yrs. 216-28-0162 100 Sept. 17,1900 Director Maryland Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow 1 ☐ Yes 2 1 No Director Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with ti Department of Haatih and Mental Hygiena. Important: if Item 27 is marked other than "natural", or itema 23a or 2 any filury or other treumatic event, the Medical Exprises must be as Pages. 856 Maple Road 21054 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, etc. 1 ☐ Never Merried 2 ☐ Married Saitimore, Maryland 21215-0036 1 Yes XXNo Specify. Specify: White by 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) Dept. of the Army Secretary 18. Mothar's Neme (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Be Charles Herbert Edgar Cassandra Price 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) J. Douglas Salyers (Son-in-law) 856 Maple Road, Gambrills, MD 21054 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 01/02 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Stephens Church Cem. 2001 Crownsville, Maryland 21. Signature of Funeral Service Moense 22. Name and Address of Facility Hardesty Funeral Home, P.A. alle 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disaase or condition rasulting in death) Coorgetorie Heart jailing Examiner Due to (or as a conseque Physician/Medical Examiner certificata be axecuted nding physician and use as the burlai-trans Sequentially list conditions, if eny, leeding to Immediate causa. Entar Undarlying Cause (Disease or Injury Que to (or as a consequence of) Box 68760 nice regurantatio rasulting in death) Last signed by the a P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown anemia Records, by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificata has lirector, paga 2 : 1 Yes 2 No 1 Yes 2 No arthurt Division of Vitai Physician: 25. Was case rafarred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Rasidence 6 Other (Specify) 10 1 Yes 2 No Aftar this 28a. Date of injury (Month, Dey Year) Certification: 27. Manner of Death 28b. Time of Injury et Work? 28d. Dascribe how injury occurred Hospital or Attending 124 hours after death. 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident ector: 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 T Homicide F 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and menner stated. 29a. Cartifiar edical To the Hosp within 24 hou To the Fune complataly fi (Check only one) 29b. Signature and file of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) Rids 31. Date filed (Month, Dey, Year) 32. Registrar's Si

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State Registra



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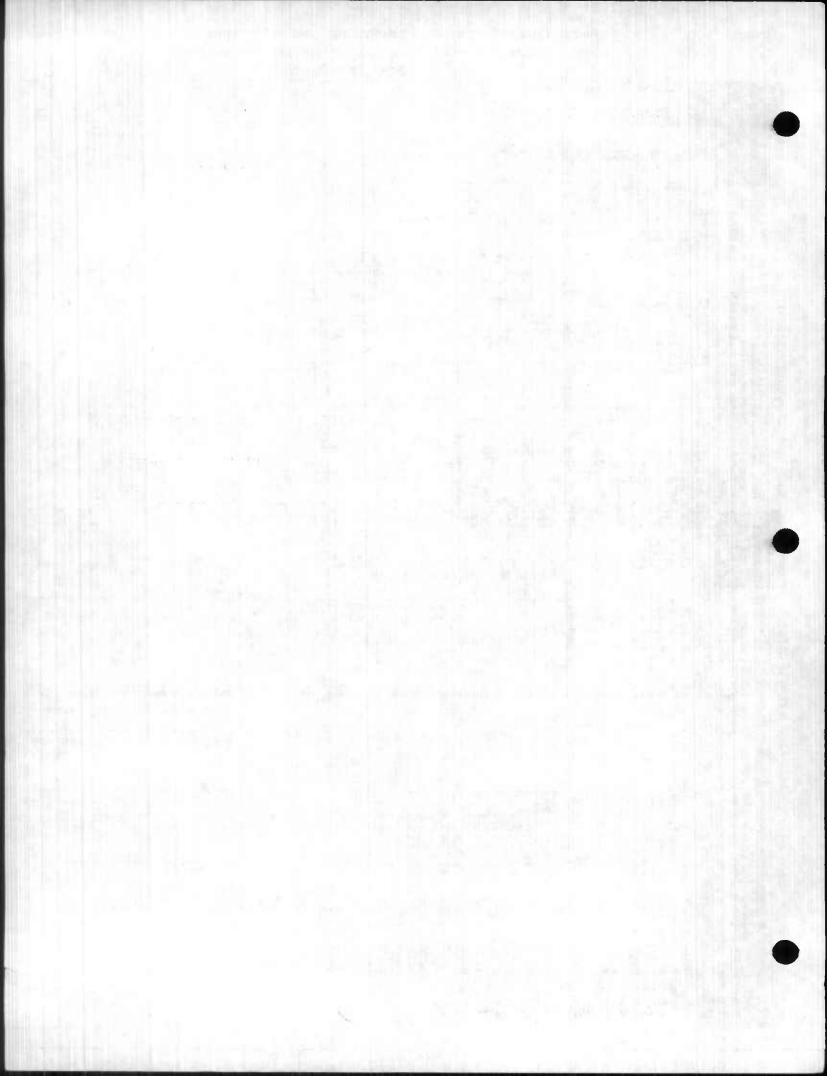
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey Year DECEMBER 30,2000 **Physician** 9:30p.m. Steven Daniel Elbert /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE if Undar 1 Yaer If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 12/21/2000 Birthplece (Steta or Foreign Country)
 MD 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1QM 20F Beys Yrs. N/A Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits 1 ☑Yes 2 No Director Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code ò 238 USA 3703 Seven Mile Lane Apt C2 21208 Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 Yes 2 No
If Yes, Give
Year or Detas: 1 Never Merried 2 Married 6 1 Yes 2 No Specify: Specify. Àq 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Fether's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) is marked of Nevla Barbanuyk Aleksander Elbert Pages 1 and 2 should 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3703 Seven Mile Lane Apt C2 Baltimore MD 21208 Aleksander Elbert Father Separtment of Health mportant: if Item 27 20b. Place of Disposition (Neme of cemetary, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/2/01 Druid Ridge Cemetery Pikesville, MD 22. Name end Address of Facility
11824 Reisterstown Road 21. Signeture of Funeral Service Libe Eline Funeral Home Reisterstown, MD 21136 Approximate Intervel Between Onset end Deeth 25a. Partt. Error the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock or heart failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Hyps Mulic left Heart Syndisme Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of) use es the burial-trer Box 68760. thet initiated events resulting in deeth) Last Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably 4 Unknown signed by by Records. page 2 should be 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Medical Certification: To Be Completed After this certificate hes 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: "
with a Hour iller deeth.

To the Tunenel Director: After this certification in by the funeral director; I 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end titla of certifier myran C. montille 4.0. 018929 12-31-00 30. Neme endaddress of person who completed cause of death (Item 23e) (Type, Print) MONTILLA. - GREATER BALTIHORE MEDICAL CENTER H-1. 31. Dete filed (M 32. Registrer's Signety State Registrar

DHMH 16 Rev 6/95



Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stelly filled in by the funeral director. To the Hospital within 24 hours a To the Funeral Completely filled

State

Registrar

30. Name and address of person who completed suse of death (Item 23e) (Type, Print) THE DOONE M. King 31. Dete filed (Month, Day, Year)

29b. Signeture and title of certified

32. Registrar's Signeture

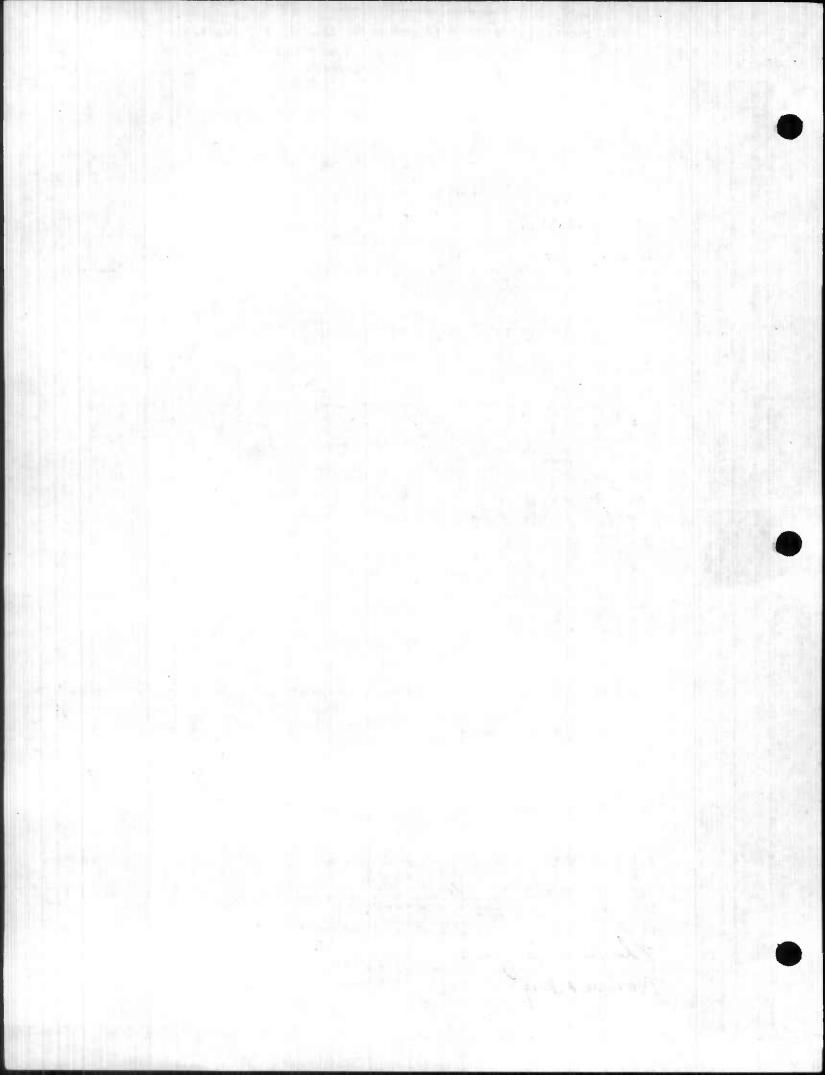
111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 28, 2000



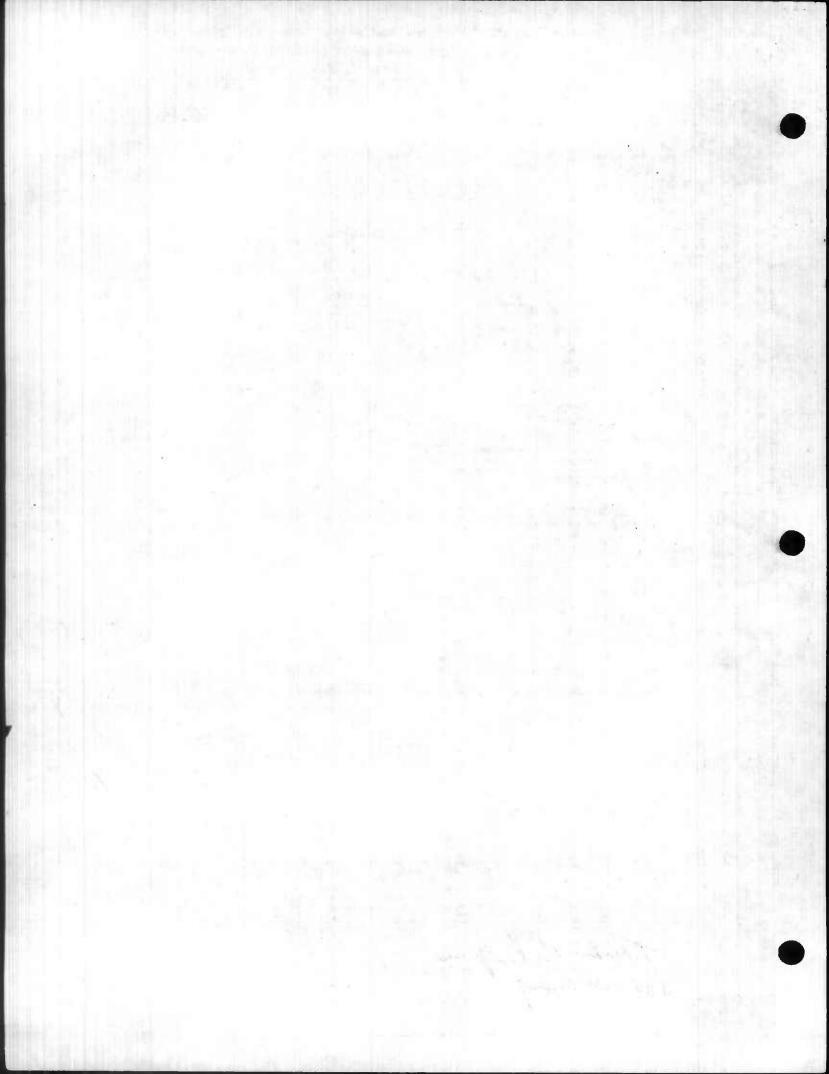
MARY ENEY 00-7478-005 RJD

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AME	State of Maryland / Department of Heal END# 23,27,&28 per ME G793_030901 SS Certificate of Dea		2014					
Physician /Medical	de Frailite Name // act institution aire stand and authors	2. Dete of Death Month Day Year DECEMBER 27, 2000 ty, Town, or Location of Deeth 4c. County of Dee	3. Time of Death					
Examiner Funeral Director	8337 I.IBERTY RD RAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If U	DALLSTOWN BALTIMORE Inder 24 Hrs. 8. Date of Birth 9. Bir	thplace (State or Foreig					
death with the Maryland ims 23e or 28e-f show count be notified neral Director	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limit					
	MD Baltimore Merrymount		1 ☐ Yes 2 ☑ No					
	10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Co	ountry?					
or after or the control of Fu	3 Widowed 4 Divorced Yeer or Detes:	U.S.A. ilc Origin? (Specify Yes or No- exican, Puerto Rican, etc.) 14. Race - Am Bleck, Whi Specify: Wh	te, etc.					
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Men metic To	Joseph Albert Romoser	Mary Elizabeth Gibney	7.0.11					
th and 7 Is m traun	19e. Informent's Name/Reletionship (<i>Type, Print</i>) 19b. Meiling Address (<i>Street</i> and <i>N</i> Frances Anderson (Sister-in-Law) 8331 Liberty Ro	Number or Rural Route Number, City or Town, Stete, ad: Merrymount, Maryland						
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permit. Pa Departmen Important any injury atios.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral 8728 Liberty Road; Randallstown, Man							
Chesician who we was the partial transit trans	Immediate Ceuse (Finel disease or condition resulting in death) e. DEHYDRATION AND INANITION DUE TO ALZE Due to (or es e consequence of): b. Due to (or es e consequence of): any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of):	HEIMER'S DISEASE	Onset end Deeth					
v requires that the death certific been signed by the attending p should be detached for use as letted by Physician/Medicted by Physician B	d	Pert I. 23b. Did tobacco use contribut	e to the cause of deat					
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or Attending Phater death. Director: After the in by the funeral artification:	1 Inpatient 2 EN/Outpatient 3 DOA 4	Nursing Home 5 Residence 6 Other (Spi 28d. Describe how injury occurred 2 No subject ate and drank 28f. Location (Street and Number or F City or Town, State) 8337 Liberty Rd., Rand	SCENE 1ess Rural Route Number,					
To the Hospital within 24 hours a vithin 24 hours a completely filled medical Ce	29e. Certifier 1□ Certifying Physician: To the best of my knowledge, death occurred at the time, da (Check enty one) 2☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner steted.	ate and place, and due to the cause(s) and manner a	is stated.					
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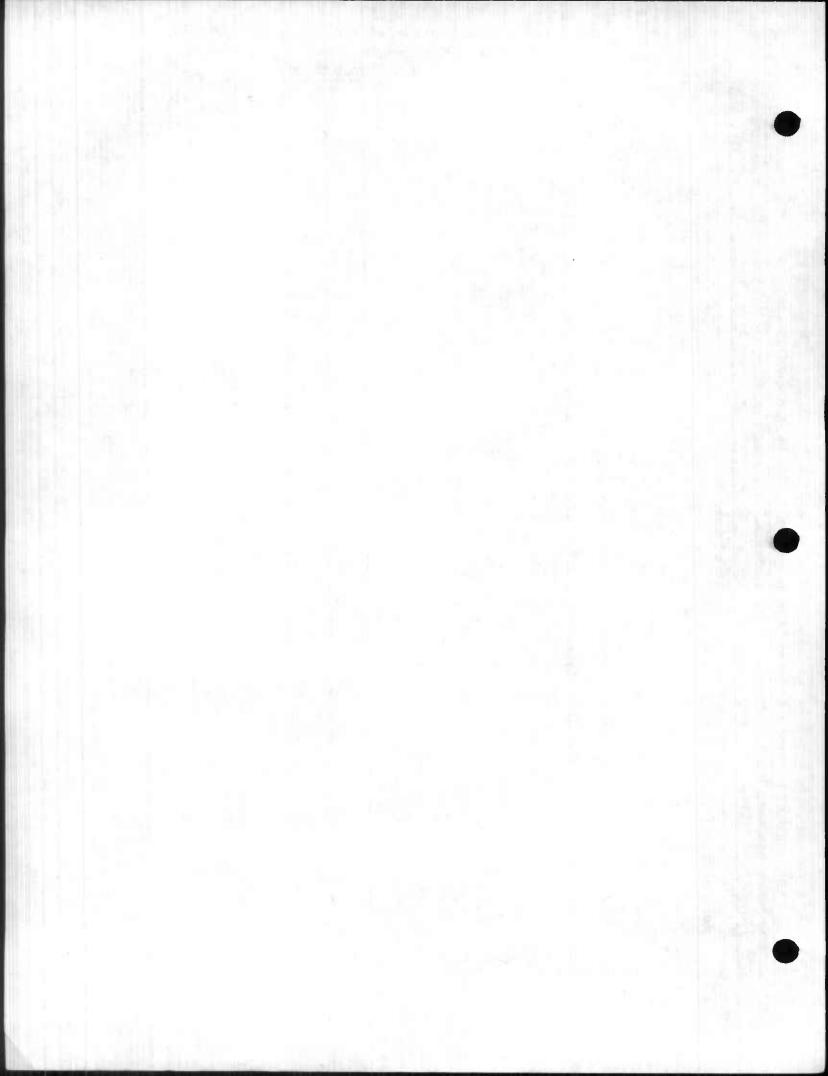


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician	1 Decedent's Nam						Death		P	eg. No.		
Physician	1. Decedent's Main	a (First, Middla, L	ast)						2. Data of Dea Month	f Death 3. Tima of Death		
/Medical	TIPHELIA ERAMAS								Decembe		2000	8:114
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Francisco Contractor	5. Social Security N			. Aga (In yrs. last	birthday)	If Under 1 Yaa		MORC 24 Hrs.	8. Data of Birth			ieca (Stata or Fora
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death nsol 27,2000 December 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Rehab + tendellar Balto If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. lest birthdey) 8. Date of Birth Birthplece (State or Foreign Country) Months Deys Hours M 2□ F Yrs. 87 216-20-9129 4/13/1913 MARYLAND Usuel Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE HILLENDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8102 HILLENDALE ROAD 21234 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1X Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried 1 Yes 2√ No Specify. Specify: 3X Widowed 4 □ Divorced WWII WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) 8th GRADE MECHANIC TOWSON FORD 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ALBERT MERRYMAN ENSOR MATILDA MAY UNAVAILABLE 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) PHILIP ENSOR 8102 HILLENDALE ROAD BALTIMORE, MD 21234 20b. Pieca of Disposition (Name of cametery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, State Buriet 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY MEM. GAR. 12/29/00 COCKEYSVILLE, MD 21. Signature of Funeral Service Licansee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. tayes 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not shock, or heart feiture. List only one ceuse on each line. 21.286 Approximate Intervat Between Onset end Death RAVEN BLVD. TOWSON, MD Immediate Ceuse (Finat disease or condition resulting in death) Due to (or es e consequença of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events Due to (or es e consequenca ot): that initieted events resulting in deeth) Lest Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 didnknown 24b. Were eutopsy tindings evailable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Plece of Death (Check only one)

Physician /Medical Examiner

certificate be axecuted

Box 68760

Division of Vitai Records, P.O.

Physician

/Medical

10a State

MD

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

?? Is marked other than "natural", or frams 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after end Mental Hygiena. Is marked other than "natural", or the

permit. Pages 1 end 2 sh Departmant of Health end Important: If Item 27 la m

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any injury

Hygiena.

Saitimore, Marviand 21215-0020

the Maryland

death

Examiner Physician/Medical use Po þ 8 Completed page 2 Be 0

Medical

2 Accident

3 Suicide

4 Homicide

ng physicien and as the burial-transit ed by the a signed peen hes Hospital or Attending Physician: 24 hours after deeth. this Certification: aftar deeth. Director: Aft filled in by

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: 4 Mursing Home 5 Residence 6 Other (Specify)

Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 1 (Naturel 5 Pending investigation

6 Could not be 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

+ fended Care Center VAMC

1 Certifying Physictan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29e. Certifier end menner steted.

29d. Date signed (Month, Dey, Year) 29c. License number

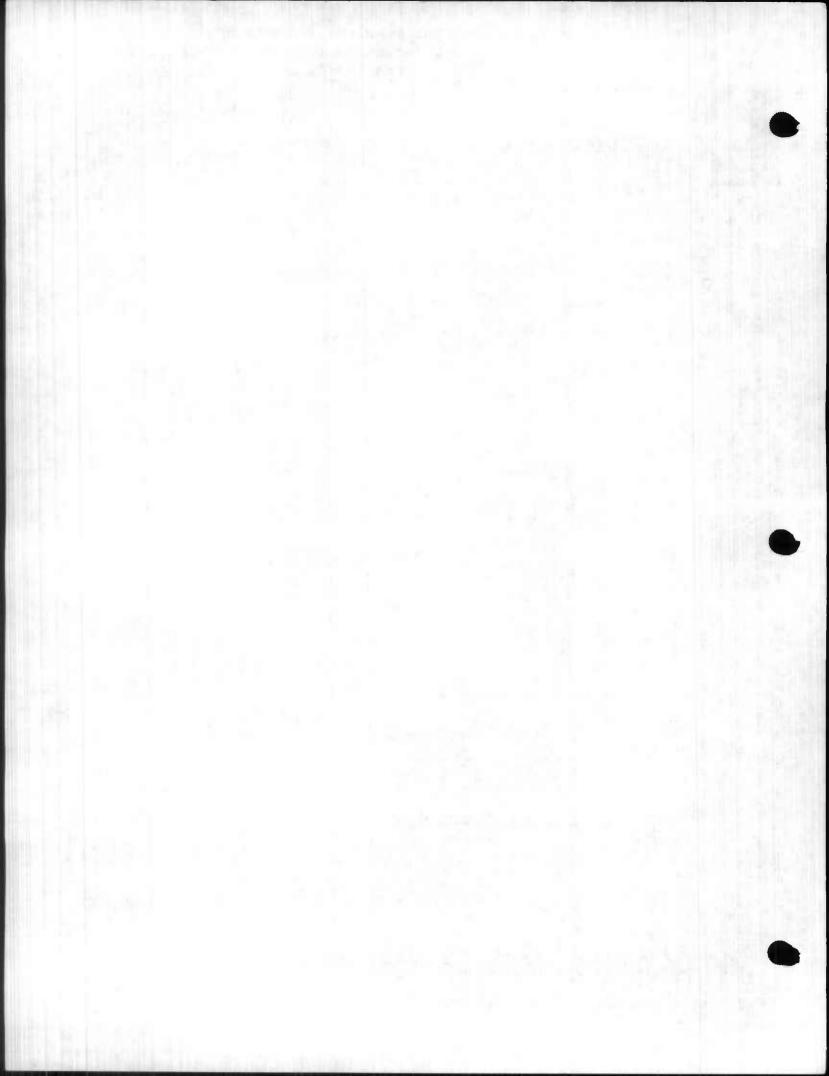
29b. Signeture and titte of certified

December 28, 2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Balto)avid M.D. 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture JAN 03 200 2 Rycha

Registrar **DHMH 16 Rev 6/95**



completely To the To the To the F State

Registrar

31. Data filed (Month. Dav. Year) JAN

29b. Signature and fittle of certifies

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30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

-LACONLOCKE, ML

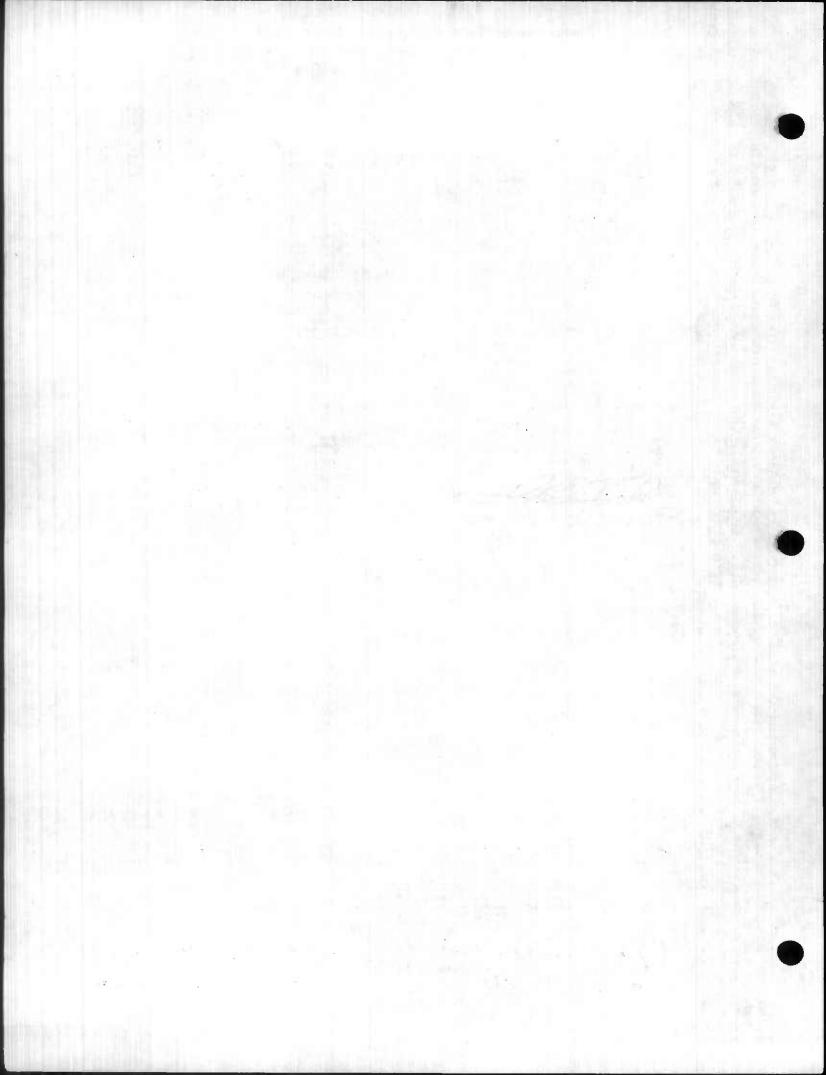
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29c. Licensa number

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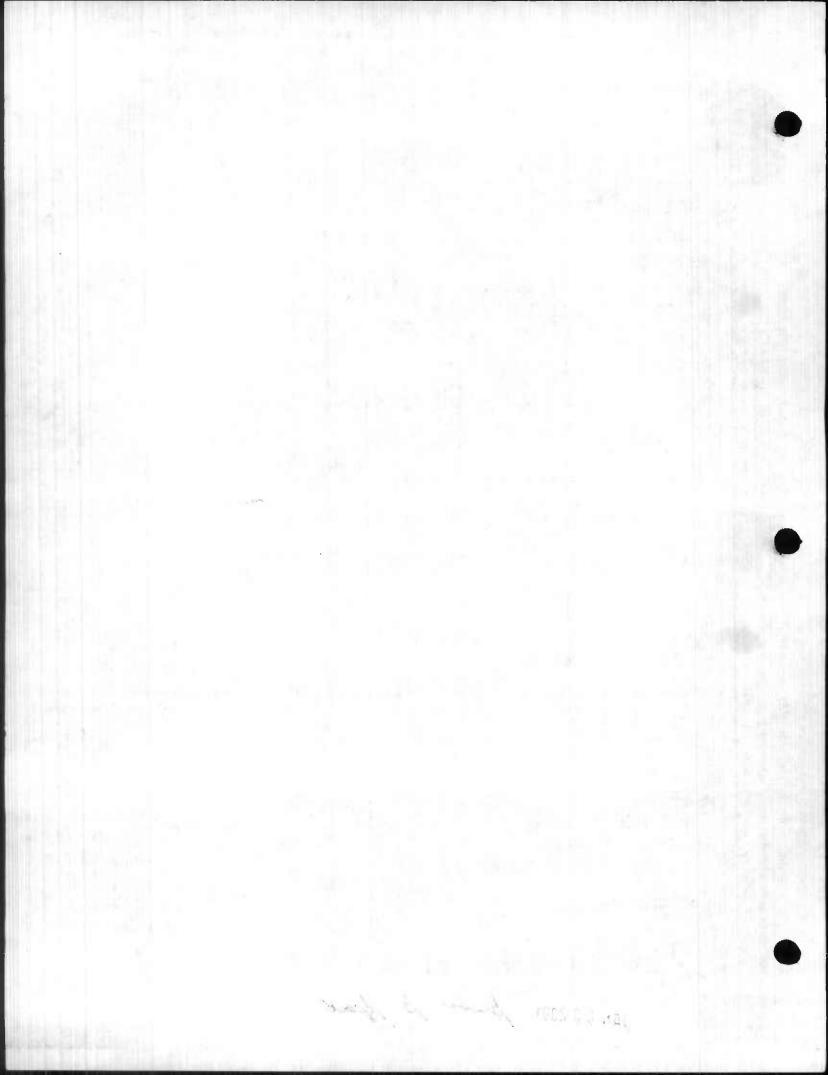
29d. Date signed (Month, Day, Year)

DECEMBER 29,2000



Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Cer	tificate of	Death	Re	g. No. () ()	42018
	1. Decedent's Name (First, Middle, La	st)		100	-	2. Dete of Deeth Month		3. Tima of Death
Physician /Medical	Vera	R.	Fre	edenbur	q	Decembe		
Examiner	4a Facility Name (If not institution, giv	a street end number)			4b. City, Town, or L	ocation of Death	4c. County of De	
	Heart Home assis				Annapo		Anne A	
Funeral	Social Security Number 6. S	ITM OFF	rs. last birthday)	Tf Under 1 Year Months Days		8. Dete of Birth (Month, Dey,	Year) 9. B	irthplece (State or Foreign Country)
Director	216–18–4349 Usuel Residence of Decedent	79	Yrs.			Nov. 22,	1921 M	aryland
within 72 hours after death with the Maryland than "netural", or frem 23s or 28s-f show he Medical Expressor must be notified at he motified by Funeral Director	10a. Stata 10b. County	10c. (City, Town or Loc	ation				10d. Insida City Limits
28a-f show	Maryland Anne Ar	Cobrum	ibson Is	back				1 ☐ Yas 2 No
23s or 28s-f should be nourised at	10e. Street and Number	. under G.	IDSOIL IS	10f. Zip Code		10	g. Citizen of Whet	Country?
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Examiner m by Funer	1 Nevar Married 2 Married	1 ☐ Yes 2 No				Rican, etc.)	Black, WI	nita, etc.
n marked other than "natural", or imatic evant, the Medical Examinatic evant, the Medical Examinatic evant, the Medical Examination of the Medical Examinati	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Dates:		☐ Yes 2 No	Specify:		Specify:	White
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H Ham 27 Is marks or other traumatic TO	19a. Informent's Name/Reletionship (Type, Print)	19b. Mailin	g Address (Stree	t end Number or Ru	ral Route Number,	City or Town, Stete	21056
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r riam 27 rr other t	20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremetion 3 ☐		. Plece of Dispos cemetery, crem	sition (Nama of setory or othar pla	ece)	Date 2	Oc. Location - City	or Town, State
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ha fu	2 Accident investigation			M 1	Yes 2 No			0
af Director: After tiled in by the funere Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			et, factory, office		281. Location (Str. City or Town,		Rurel Route Number,
To the Funeral Director: Affar the completely filled in by the funeral Medical Certification:							Series.	
plataly fil edical		ysician: To the best of my kinner: On the basis of exemi						
Te the Funeral completaly filled Medical C	one)	end menner steted.	TIONOTI BITGOT III					
48	29b. Signeture and title of certifier	110	-	29c. Licen	nse number	29	d. Date signed (Mo	onth, Dey, Year)
10	/www	-	-		0719	27	12-2	4-00
1	Neme and eddress of person who	complated causa of deeth (It	em 23e) (Type, F	Print)	11.0 h	1#2011	Centerr	a Park
	Obleca &	PonUD 4	79 Ju	malis	Hole Ro	1.307	MD	21146
State	31. Vate filed (Month, Dey, Year)	32. Registrer's Sig	mature 4	Ina	Sil			
Registrar	JAN 03 21	101	1	1300				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death 150 9 (4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 0/433 orien NUVS If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 50 Yrs. If Under 24 Hrs. Birthpiece (State or Foreign Country)
 PA 220-56-6857 Deys Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. Prince George's Laurel 1 Yes 2 No 109. Street and Number 10300 Bristolwood Ct. 10g. Citizen of Whet Country? 10f. Zip Code 20708 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Yeer or Detes: 11. Meritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Merried 2 Married specity: white 1 Yes 2 No Specify: 3 Widowed 4 Divorced 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buelness/Industry Elementary/Secondary (0-12) College (1-4or 5+) computer specialist Social Security 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Frank Thomas Dresser Mary Kathryn Johnston 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Dresser, mother 10300 Bristolwood Ct., Laurel, Md. 20708 20b. Piace of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removei from State 1/4/01 Laurel, Md. Baltimore/Washington Crem. 4 ☐ Donetion 5 ☐ Other (Specify) 22 Nome and Address of Facility Fleck Funeral Home, Inc. 21. Signeture of Funeral Service Licensee M00741 7601 Sandy Spring Rd., Laurel, Md. 20707 ran Semmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Immediate Ceuse (Final disease or condition resulting in deeth) PTVOKE Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 25. Was cese referred to medical 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 Tes 2 Accident 6 Could not be 3 ☐ Suicide

Examiner the burial-transit or Attending Physician: The law requires that the death certificate be exe P.O. Box 68760, for use es been signed by the e should be deteched Records, page 2 this cartificate Division of Vital After

Physician/Medical Examiner þ Be Completed Medical Certification: To

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours after of Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner.

Physician

/Medical

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21215-0020

Baltimore, Maryland

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To the Funeral Director: Aft completely filled in by the fur

> State Registrar

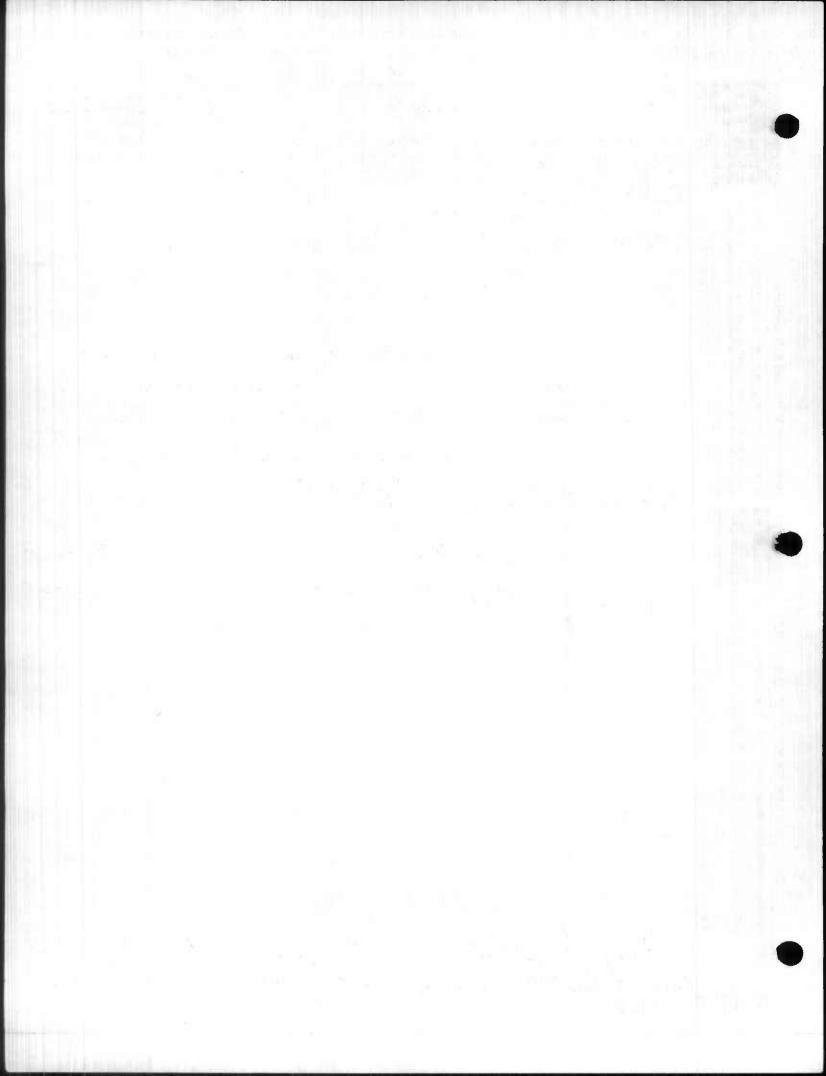
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2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

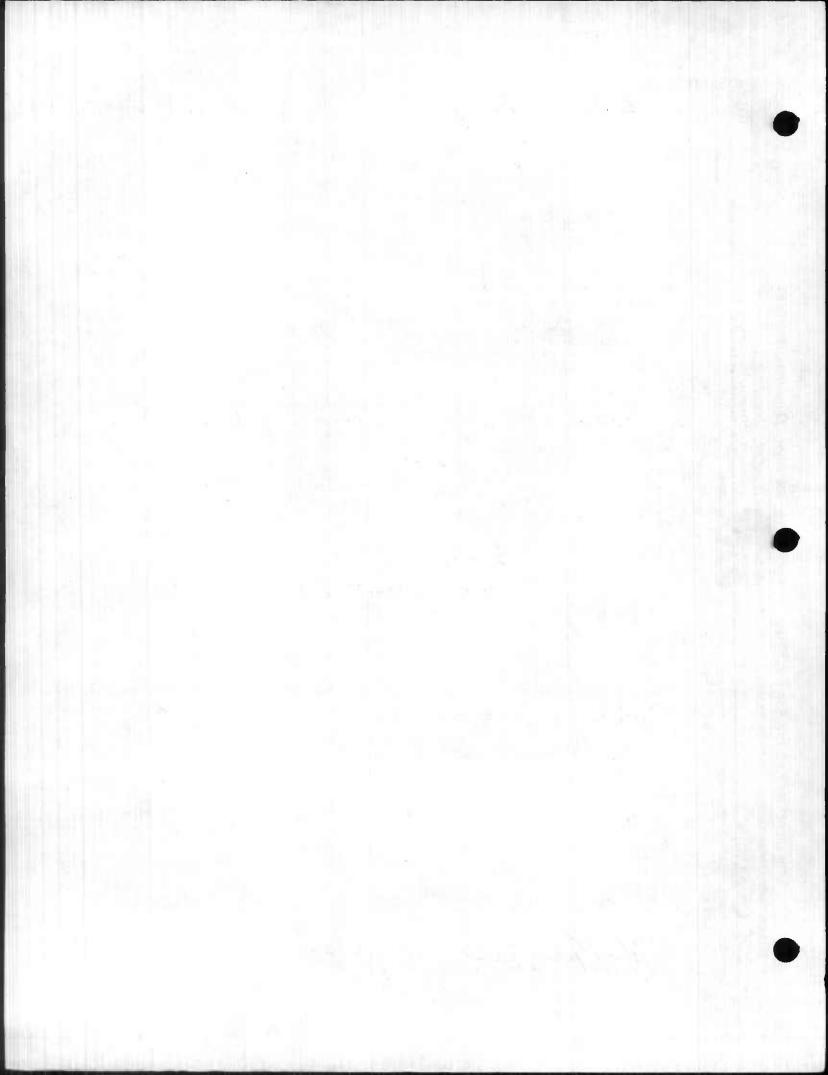
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 430 PM **Physician** December LINDA 2000 23 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Prince George's Laurel Cherry Lane Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 03/04/1946 9. Birthplaca (Stata or Foraign **Funeral** 1□ M 207F Months Days Hours 234-07-4021 Yrs. Washington D.C. Director 54 Usual Rasidence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylen Department of Health and Mental Hydisona. Important: if item 27 is marked other than "natural", or frems 23a or 28a-f show any fujury or other traumatic event, the Medical Examination must be notified. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yas 2 No Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9000 Cherry Lane 20708 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 M No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Unemployed Disabled 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surnama) Be Essie Shrader Robert Farley 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Carol Staehlin Niece 1714 Manning Road Glen Burnie, MD 21061 20b. Place of Disposition (Nema of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Woodlawn Mem. Park Bluewell, WV 12/27 22. Nama and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc. 21, Signatura of Funaral Sarvice Lice 736 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Sepsis hours Examiner Dua to (or as a consequence ot): Physician/Medical Examiner ringra physician and s the burial-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaase or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760, Dua to (or as a consequence of): signed by the atte P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2500 3 Probably 4 Unknown Thyperknsion, Coronar Division of Vital Records. Completed by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? should 2 No 1 ☐ Yas 2 ☐ No 1 Yas Attending Physician: 25. Was case refarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) Medical Certification: To 1 Yas 3 No 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. tnjury at Work? After 1 Natural
2 Accident 5 Panding investigation To the Hospital or Attandir with 24 hours after death. To the Funeral Director: At 1 Yas 2 No 6 Could not be datarmined 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) Med in by 4 Homicide 15/Certifying Physician: To the best of my knowledge, death occurred et tha time, date end place, and due to the causa(s) end manner es stated.
2 Medicat Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) December 24, 2000 on with completed causa of death (Item 23a) (Type, Print)

13952 Battimore Ave, Lavrel, MD 20707 30. Name and address of per MARGOLIS 2001 Augusta 31. Data filed (Month, Day, Year) State JAN 03 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Year Martha Gohn 4:30 am December 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hopkins Bayview Medical Center Baltimore Baltimore City If Under 24 Hrs. Z/Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Dete of Birth (Month, Dey, Year) 9. Birthplace (Stete or Foreign Months Deys Hours 724797 1 M 2 M Usual Residence of Deceder 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5+ 21 ART 60 on Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race 11. Merital Stetus 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHI 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLY LINE WORKER 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) INKNOWN IRENE WILLITAMS 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, cremetory or other place) ZSSEX AB IS TRENE RAKOWSKI 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State SAY VIEW CREMATOR 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service License 22. Name and Address of Facility AUI ASTEMN AUG 6 23a. Part. Enfer the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting in death) End Stage Renal Disease 3 weeks 2 weeks notic Brain Due to (or es e consequença of) 5 years Congestive Heart Failure Due to (or as e consequenca of): 5 years Renal Tubular Acidosis 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 1 No 26. Place of Death (Check only one) 1∏Yes 2MNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner

The law requires that the daath certificate be execu

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral Director

by

Completed

Be

Funeral

Director

th end Mental hygiene. 7 is marked other than "natural", or frems 23s or 28s-f ahow traumstic event, the Mexical Examinar must be notified at

. Pages 1 and 2 should be fill timent of Haalth end Mental Hant: if Item 27 is marked oth jury or other traumatic even

permit. Pages Department of Important: If It any Injury or o

the Maryland

filed within 72 hours after deeth with

Baltimore, Maryland 21215-0036

Examine attending physicien and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Physician/Medical signed by the a

Completed by

Be

10

Certification:

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should I

s certificate has b director, page 2 s

director,

funeral

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filled in by

complately

To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifical

25. Was case referred to medical examiner? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. tnjury et Work? 1 PNatural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

3 ☐ Suicide 4 Momicide

(Check only one)

29e. Certifier

6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) end manner steted.

29b. Signature and title of certifier Myeua Gotlomeur, MD Resident Physician

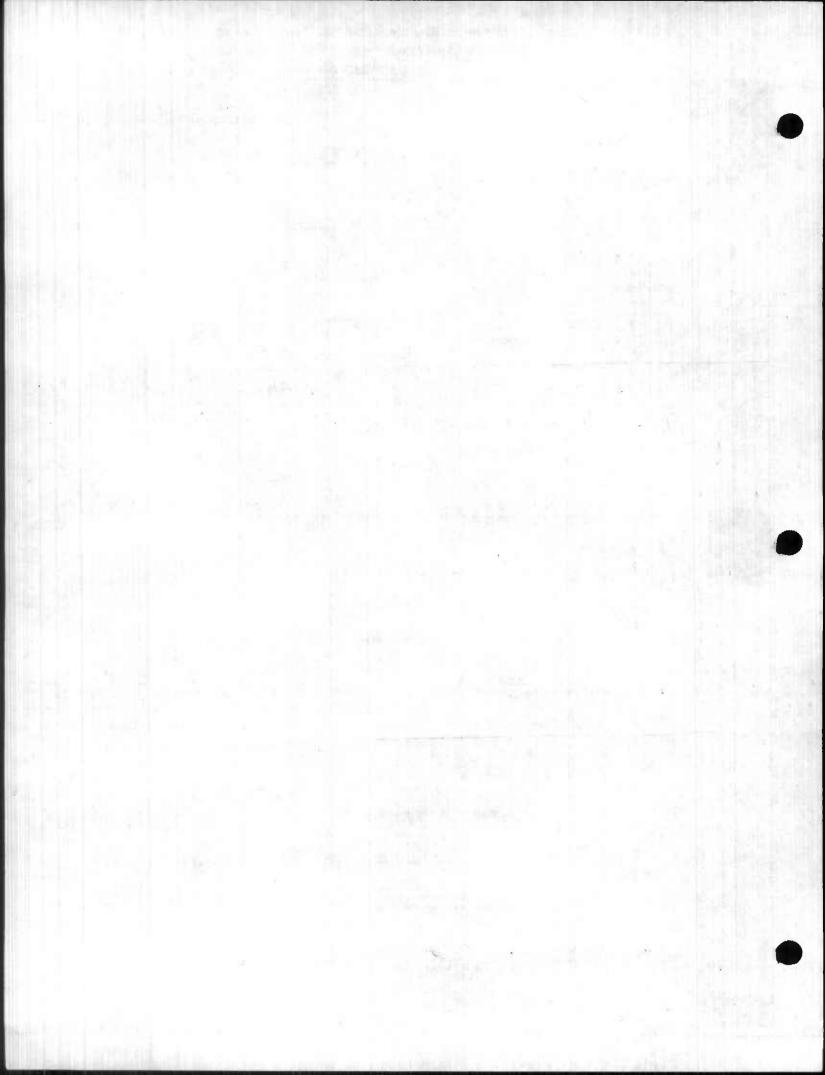
29d. Date signed (Month, Day, Year) December 8,2000

21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goftesman MD, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore hanglang

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Yeer **Physician** 29, Dec. Dannielle R. Graham 2000 12:25pm /Medical 4b City Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Johns Hopkins Hospital Baltimore If Under 1 Year 7. Age (In yrs. last birthday) 5. Sociel Security Number Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys 10 M 20 F Yrs. Director 214-11-5945 14 01-06-86 MD Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Ves 2□No MD Director NA Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 2304 E. Madison Street 21205 USA death Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 72 hours efter Never Merried 2 Merried 1 Yes 2 No
If Yes, Give X
Yeer or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Student Student . Peges 1 end 2 should be filled wi ment of Heelth end Mentel Hyglen lant: If Item 27 Ie marked other th jury or other treumetic event, me 9th Grade NA 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Latif Lawal Rachelle Graham 19e. Informent's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rachelle Graham 2304 E. Madison Street Baltimore, MD 21205 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) permit. Pege Department of Important: If any Injury or page. Greenmount Cemetery 01-04-01 Baltimore, MD 22. Name end Address of Fecility 21. Signature of Funerel Service Licensee Baltimore, Maryland 21202 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line.

WM.C.March FH 1101 E. North Avenue

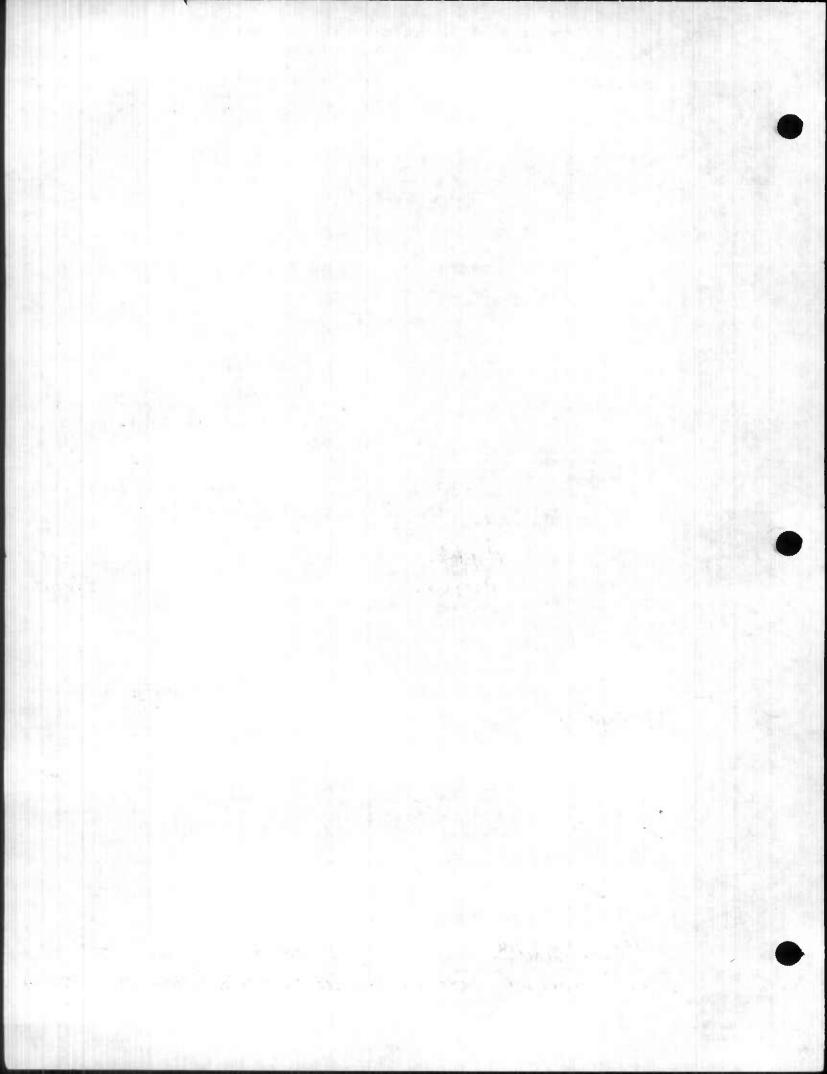
Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner The law requires that the death certificate be executed attending physician end for use es the burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the signed by t d be detach 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? should I 24e. Wes en eutopsy performed? Completed has 2 PNo 1 Yes 2 No certificate Physician: Be 25. Wes case referred to medical examiner? director 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation Attending 1 Neturel Director: Aft 1 Yes 2 No 2 Accident 8 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò Male 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number D-31403 ss of person who completed cause of deeth (Item 23a) (Type, Print) JINIA, 600 N. WOIEST., Backwore, MD 21287-3144 Walker, MD CUISC-144 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#20b perFHG791 1/3/2001 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Physician (3-REENE 41.50 000 LENNETH DEEMBER 28, 2000 /Medical 4a Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** NONTHIEST RAMMUSTOUN Hospin Cerren BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 1)X M 2□ F 5. Social Security Number 7. Aga (In yrs. last birthdey) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 242-54-3903 Months Days 60 Yrs. APRIL 10, 1940 NORTH CAPOLINA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show BALTIMORE 1 Yes 2 No Director MARVLAND 10e. Street and Number 10g. Citizen of What Country? 6 2 21244 KOAD 238 USA. 14. Race - American Indian, Hema: 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, White, etc. 1 ☐ Navar Married 20 Married 21215-0020 "natural", or 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced -AC Completed 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) CHURCHI SHAW U.M. altimore, Maryland 17. Father's Nema (First, Middla, Last) permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked offine any Injury or other treumatic event ans. 18. Mother's Neme (First, Middle, Maiden Sumame) Be BROWN HAVWOOD GREENE 4, WALTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DANDRA MARIE GREEKE (WIFE BALTIMORE, MD. 21244 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Steta 20b. Place of Disposition (Neme of cematery, cremetory or othar plece) Date 20c. Location - City or Town, Stete DRIUD RIDGE CEMETERY 01-05-01 BALTIMORE, MARYLAND

22. Name and Address of Fecility 2. The Full Fig. 1. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses BROWN JR. FUNERAL Home 0,55 PH FULTON AVE. 23a. Part1. Enter the disaase, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death Physician /Medical fmmediate Cause (Finel disease or condition resulting in death) Acute Myocanoim HOUR Examiner Due to (or as a consequenca of): Examiner CORONARY YEARS ANTOLY Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Box 68760, HYPERTENSIVE CANDIOUASCULAR DISEMSE EARS Physician/Medical the Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? MELLOUS DIABETES Records. 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? CONGESTIVE HEART MORBID OB ESIT 1 Yes 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ SP/Outpatient 3 ☐ DOA 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To funaral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Hospital or Attending P
 Abours after death.
 Funerel Director: After Division Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Descritifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. Medical 29a. Certifier

State Registrar

complataly within 2 To the \$

> 31. Date filed (Month, Day, Year) JAN 3 2001

BONT FINE

MD 5401 32. Registrar's Signature

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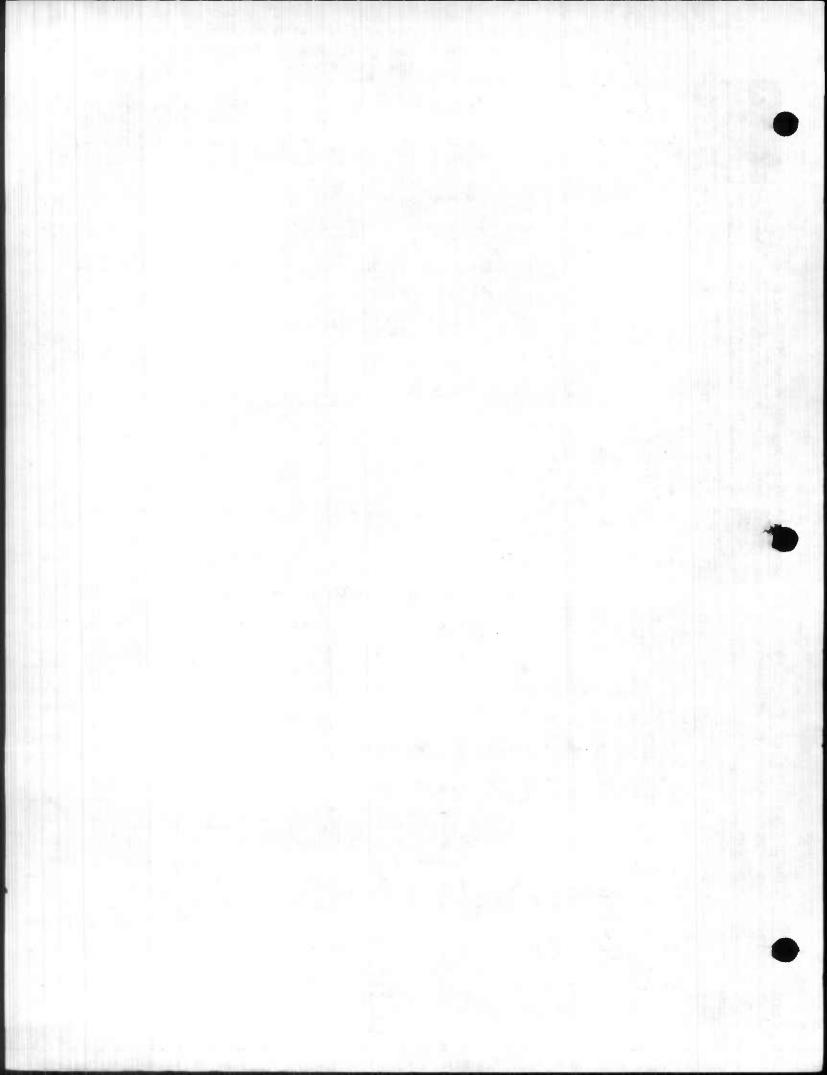
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLD COUNT RD

29c. License number

29d. Date signed (Month, Day, Year) DECEMBER 28, 2000

RANDALLSTOWN MD 21133



LORENCE

H. Barrery A. H. Description of the second

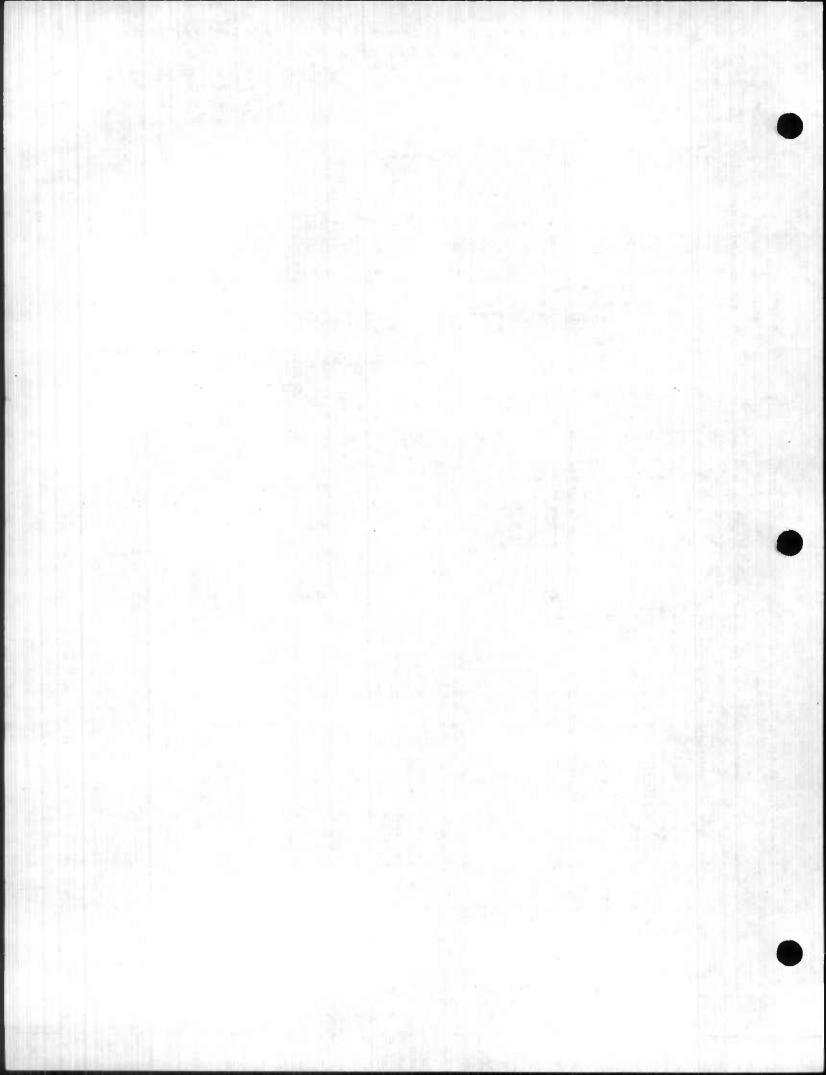
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Lorraine A. Geyer 12 28 2000 3:00PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Franklin Woods Nursing Home Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. 8. Dafe of Birth (Month, Dev. Year) Birthplaca (State or Foreign Country) Funeral Months Deys Hours 1 M 2 XF 215-18-8843 Director 78 05-14-1922 MD Usual Residence of Deceden the Meryland 10e Stafe 10b Counts 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Streef end Number 10f. Zip Code 10g. Citizen of What Country? 7452 Edsworth Road 21222 USA Pages 1 and 2 should be filed within 72 hours efter death neat of Health and Mental Hygiene.
wit: if item 27 la marked other than "natural", or items 23.
ury or other traumatic avent, in a section from man Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Merital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Caucasian à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 0 Food Handler Balto, Co. Schools 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Henry Juister Fredericka Rock 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) Leroy Geyer 7452 Edsworth Road, Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Depertment of Important: If it any Injury or on 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State Green Mount Cemetery 1/1/01 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signefure of Funerel Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 23d. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or in cause on each line. acorowska MD 21222 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Nonis Examiner Due to (or es e consequence of): Examine and I-transit death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or as a consequence of) attending physician a for use as the burial-Box 68760. Physician/Medical Due to (or es e consequence of): signed by the a P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. þ The law requires 24b. Were eutopsy findings evailable prior to completion of cause of death? should b 24a. Wes en eutopsy performed? Completed il director, page 2 sl 20 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: Affer this certifical completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Oufpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mennes-of Death 28b. Time of Injury 28c. fnjury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - Af home, ferm, sfreef, factory, office building, etc. (Specify) 4 Homicide Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated.

| Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated.

| Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifin 29c. License number 2 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ruhmana, 8100 Harford Road, Baltimore, Maryland 21234 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State JAN Seguera Registrar

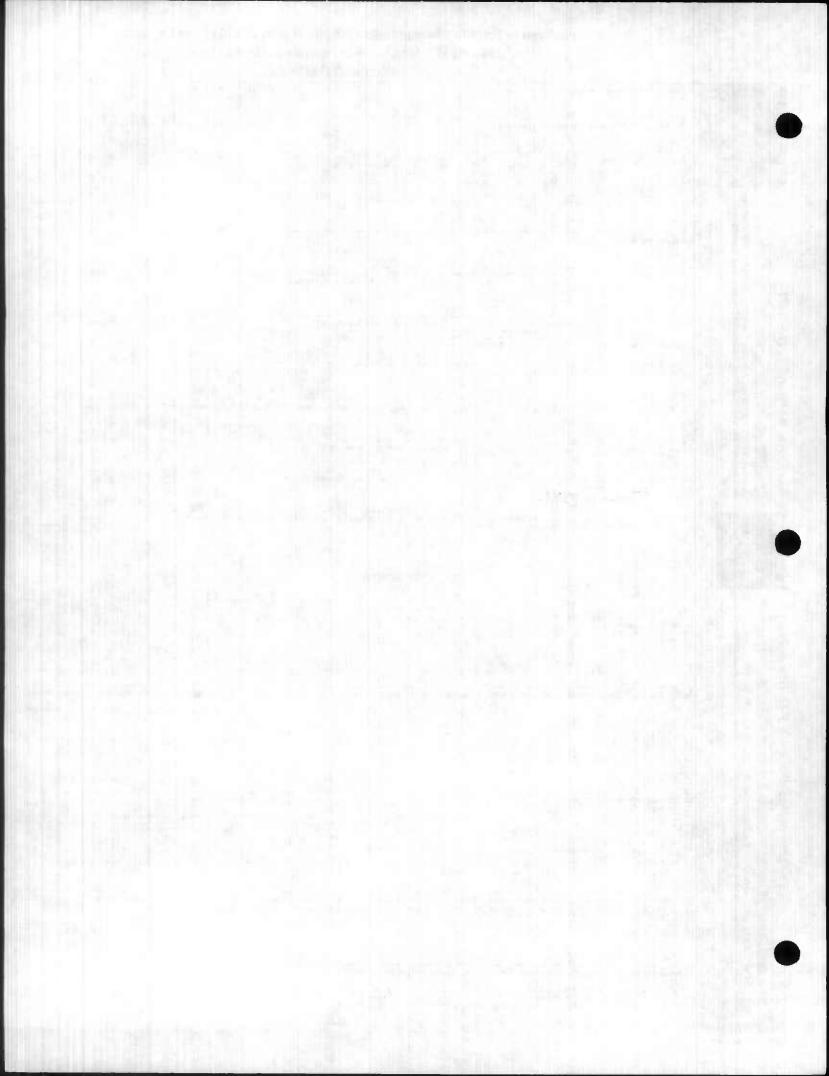
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			Certificate of Death	Reg. No.	42026			
		Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Tima of Death			
ALI.	Physician /Medical	Irvin Daniel Gleason		Month Day Year Dec. 26 2000	5:46 AM			
4	Examiner	4a Facility Neme (If not institution, give street end number)	4b. City, Town, or Lo	ocation of Death 4c. County of De	ath			
		Manor Care Ruxton Nurising Hom			ore			
	Funeral Director	5. Social Security Number 6. Sex 1 № 2 □ F 7. Age (In yrs. lest b	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year) October 24 1911	irthplace (Steta or Foreign Country) Maryland			
Pu	3	Usuel Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits			
lenyle	P. P.	Maryland Baltimore Baltin			1 ☐ Yas 2 ☒ No			
he N	or 28a-fe be notified Director	10e. Street and Number	10f, Zip Code	100 Chinas of Minas of				
ath with	23a or	53 Murdock Road	21212		10g. Citizen of Whet Country? United States			
d 21215-0020 filed within 72 hours effer death with the Meryland	*natural*, or tems 23a or 28a-f show addal Examinar mast be notified at leted by Funeral Director	11. Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? 1 Nevar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar in U,S. Armed Forcas? 1 Yes, Giva Year or Dates:	 13. Was Dacedent of Hispanic Origin? (Spell Yas, specify Cuban, Mexican, Puarto 1 ☐ Yes 2 ☒ No Specify: 		narican Indian, lite, etc. White			
15-C		15. Decedent's Education 16 (Specify only highest grade completed)	Sa. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Busines	s/Industry			
withir		Elementary/Secondary (0-12) College (1-4or 5+)			wino			
d 2	C if a	17. Fathar's Name (First, Middla, Last)	Supervisor/Drafting De	e (First, Middle, Meiden Sumeme)	ILTIIB			
an	ked off	Daniel Ignatius Gleason	Lelia	Small				
Maryland	in and Mental Hyglene. 7 is marked other than traumatic event, the M		9b. Mailing Address (Street end Number or Run		Zin Code)			
	9 5		3 Murdock Road Balti		21212			
Te, N	Rem 27 other tr	20a Method of Disposition 20b. Place	of Disposition (Neme of	Date 20c. Location - City of				
Baltimore	Department of Important: If it any injury or conce.	1 A Burial 2 Li Cremation 3 Li Removal from State	tery, cremetory or other place) by Valley Memorial Cdns. 1					
Ball	mport any in	21. Signature of Funeral Service Licensee	22. Nama and Address of Facility Mitchell-Wiedefe 6500 York Rd.	ld Funeral Home I Baltimore,Maryla	nc. nd 21212			
	nam'i e	23a. Pert1. Enter the disease, or complications that ceused the death. Do shock, or heart tellure. List only one cause on each line.			Approximate Intervel Between			
Phy	ysician				Onset and Death			
10.5	ledical	Immediate Cause (Final disease or condition	& mantis		year			
Exa	aminer	resulting in death)	a consequence of):					
D	i i							
60, U	physician and s the burial-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.						
. Box 68760, Udeeth certificate be executed	0 8		a consequence of):					
D de de	d for use	Part II. Other significant conditions contributing to death but not resulting	in the underbing eques given in Red I	23b. Did tobecco use contribu	to to the sauce of death?			
P.O	igned by the attendi be detached for use by Physician/I	rath. Ours significant conditions continuing to osain out not resulting	in the underlying causa given in Part i.		Probably 4 Unknown			
of Vital Records, P	2 should			24a. Was an autopsy performed?	b. Were autopsy findings eveilable prior to completion of ceuse of death?			
E Be	page page			1 ☐ Yes 2 ☑ No	1 Yes 2 No			
/ita	certificate rector, pa	25. Wes cese referred to medical examiner?	1	h (Check only one)				
of Vita		- Hospital:	Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence 6 Other (Sp	pecify)			
Eng Fing		27. Manne of Death 1 Naturel 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Dey Year)	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred				
0 8		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	ferm, street, fectory, office	28f. Location (Street end Number or City or Town, Stete)	on (Street end Number or Rural Route Number, Town, Stete)			
Hospital	S Y	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge on the basis of examination a light of the basis of examination and manner stated.						
To the	To the Fu complete	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	nth, Dey, Year)			
		1 /hl	04547	12/28	0			
	4	30. Name and address of person who completed ceuse of death (Item 23a	(Type, Print)	OV JULIE MAIN	212211			
	State	31. Date filed (Month, Dey, Year) 32. Registrar's Signature	MAKEOKU AU, TAI	CKVICCE, MIN	21239			
	Registrar	JAN 3 2001 Deneum	D sparks					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Dala of Death 3. Tima of Death nav Month Vaar **Physician** SUE FLEMING GELSTON December 27, 2000 4:50 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Undar 24 Hrs. 8. Dala of Birth Hours Min. (Month, Day, Year) If Under 1 Yaar 5. Social Security Number 7. Aga (In vrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days 1□M 2XF Months Yrs. 215-24-1520 March 2, 1912 Director Maryland Usual Rasidence of Decedani the Maryland 10a Stala 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "naturel", or items 23s or 28s-f ahow 1 ☐ Yas 2 No Directo Maryland Baltimore Phoenix 10e. Streel and Number 10f. Zip Code 10g. Citizan of What Country? 14600 Woodbark Lane 21131 U.S.A. death Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dalas: 14. Race - Amarican Indian, 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Stalus Black, Whila, atc. 72 hours aftar 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2 X No Specify: Specify: White b 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: if fem 27 is marked other than "natu any injury or other traumatic avent, in Mental page. 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) 12 years Collega (1-4or 5+) Homemaker Own Home 18. Molhar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Henry Little Fleming Priscilla Elizabeth Williams 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 14604 Woodbark Lane Hugh E. Gelston, Jr. (son) Phoenix, Maryland 21131 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Removal from Stata 4 Donallon 5 Othar (Specify) 12-28-00 Baltimore, Maryland Green Mount Crematory 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Mitchell-Wiedefeld Funeral Home, Inc. -enais (secre 6500 York Road Baltimore, Maryland 0 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Inlarval Batween Onsat and Death **Physician** /Medical Immediala Causa (Final disaasa or condition rasulting in death) was concer Examiner Dua to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Sequantially list conditions, if any, leading to immediala ceusa. Entar Undarlying Cause (Disease or injury Dua to (or as a consequence of): that initiated evants Dua to (or as a consequance of): rasulting in death) Last ed by the s 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Yes 2 No 3 Probably 4 Unknown by cate has been signated page 2 should b 24b. Wara autopsy findings available prior to 24a. Was an aulopsy performed? Completed completion of causa 1 Yas No 1 ☐ Yas 2 ☐ No After this cartificate Physician: director, Be 25. Was cesa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatianl 2 ☐ ER/Oulpalient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Dothar (Specify) NOSP. 2 1 Yas 25 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred Certification: Injury at Work? To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: After 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident Director: A 6 Could not be 28f. Localion (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifian npletely (Check only one) 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian 200 51926 MO 28, 2000 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) 6601 N. Charles St, Baltimore MD 21204 Gordon M. and 32. Registrar's Signatura 31. Dala filed (Month, Day, Year) State oaks 3 2001

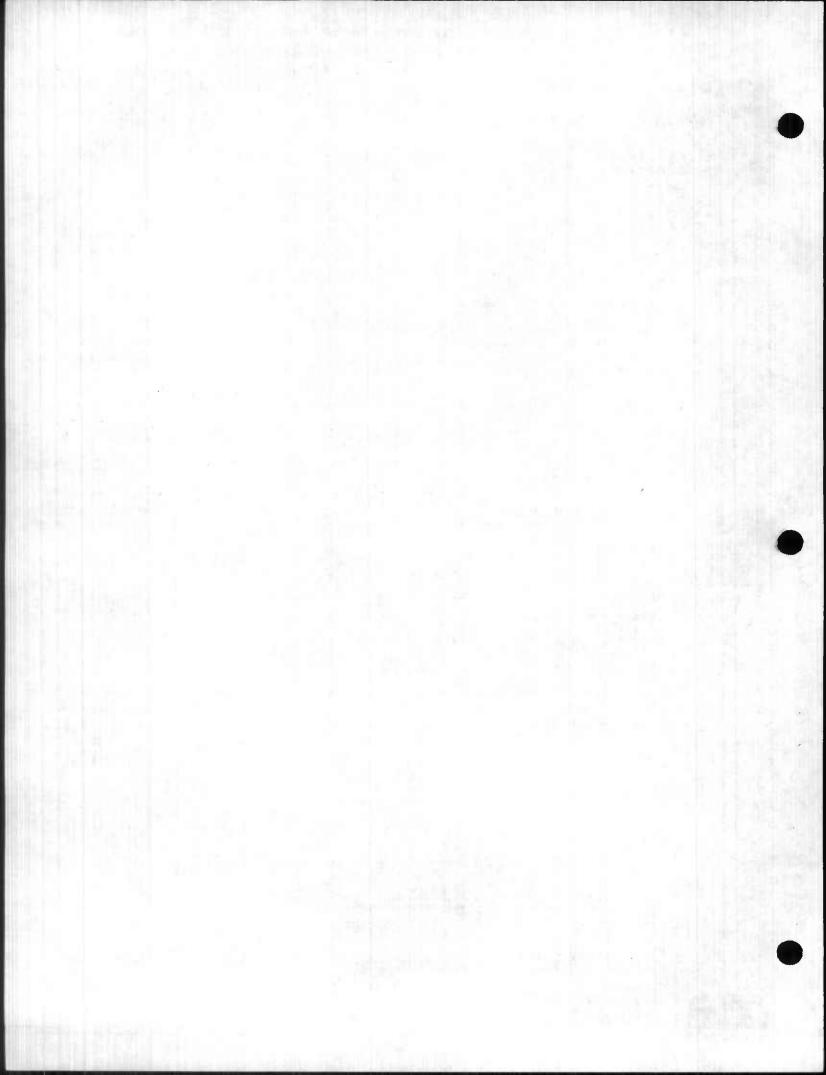
DHMH 16 Rev 6/95

Registrar

JAN

78/5701, Sue 12/27/00 4:50 pm

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death December 30 **Physician** 2240 Ophelia C. Gray ,2000 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Baltimore N/A Saint Agnes Hospi tal

5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F Months Deys 8 8Yrs. Director 237-58-3753 Apr. 3, 1912 North Usuel Residence of Decedent the Maryland 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits jiana. r than "natural", or items 23a or 28a-f ahov the Medical Examinar man be notified at 1 Yes 2 No **Funeral Director** MD Baltimore Catonsville 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 2014 Cedar Circle Drive nd 2 should be filed within 72 hours after death in and Mental Hygiana.

27 Ia marked other than "natural", or hams 23 treumatic event, the Medical Examples man 21228 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) North Carolina Elementery/Secondary (0-12) College (1-4or 5+) 12th Educator Dept. of Educ 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pagas 1 and 2 should be fill ment of Haalth and Mental Haart: If them 27 is marked off Be Lynn Carson Ollie Jackson 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pagas 1 and 2 Department of Haalth a Important: If Item 27 is any injury or other trai Ronald K. Gray, MD-Son 2014 Cedar Circle Dr. Balto. MD 21228

20b. Plece of Disposition (Neme of cametery, cremetory or other plece)

Date

Date Baltlmore. 20e. Method of Disposition 1 ☐ Buriel 2 ☐Cremetion 3 ☐ Removel from Stete 01/04 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory

22. Name and Address of Fecility 21. Signeture of Funeral Service Licensee Nutter Funeral Home Inc. 8 A orbert nutte 2501 Gwynns Falls Pkwy. Balto. 21216 MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical JOURS Examiner Due to (or as e consequence of) Physician/Medical Examiner MALIA cartificata be axecuted carificata has been signed by the attending physician and irector, page 2 should be datached for use as the bunal-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760. Due to (or es e consequence of) The law requires that the death Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy parformed? Completed onema 2 No 1 ☐ Yes 2 ☐ No 1 Yes al or Attending Physician: T s after death. Il Director: After this carifical of in by the funeral director, p Be 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 TER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2000 Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital

To the Funeral C

completely filled edical Decertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

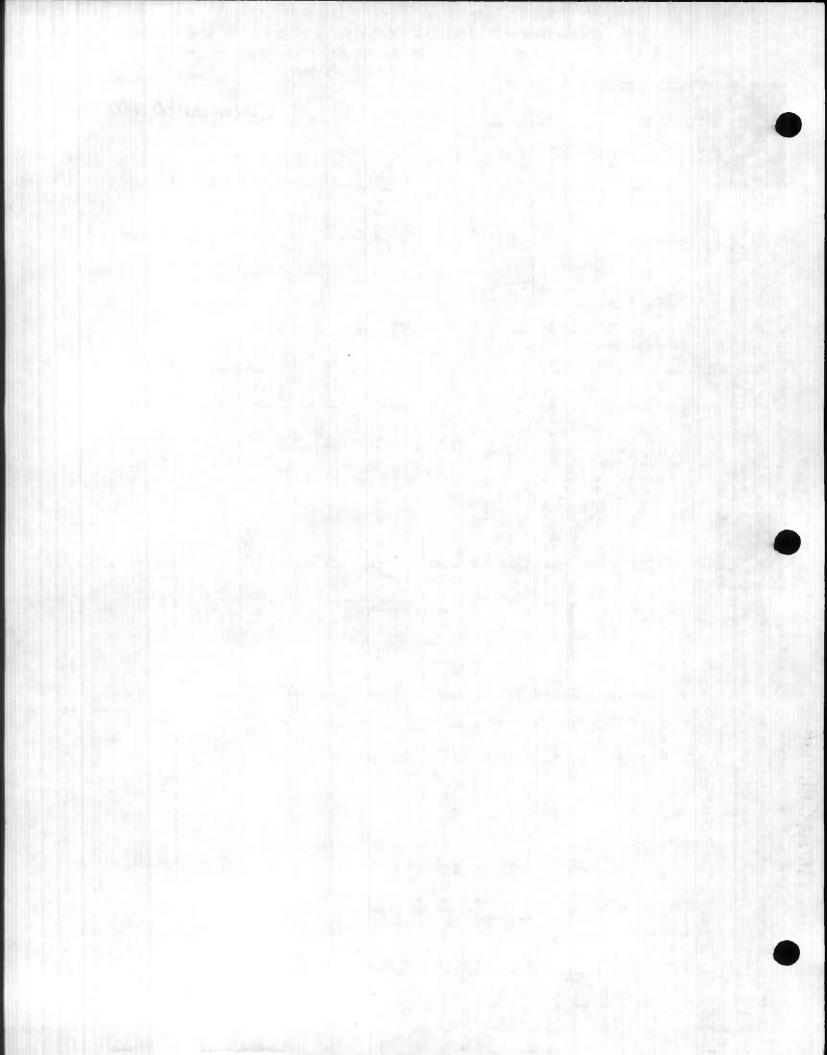
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature end title of certifier anner Neme and address of parson who completed cause of deeth (Item 23a) (Type, Print) Leare Baltimas sounders st Depondal 3) Date filed (Month, Pay, Year) 32. Registrer's Signature State

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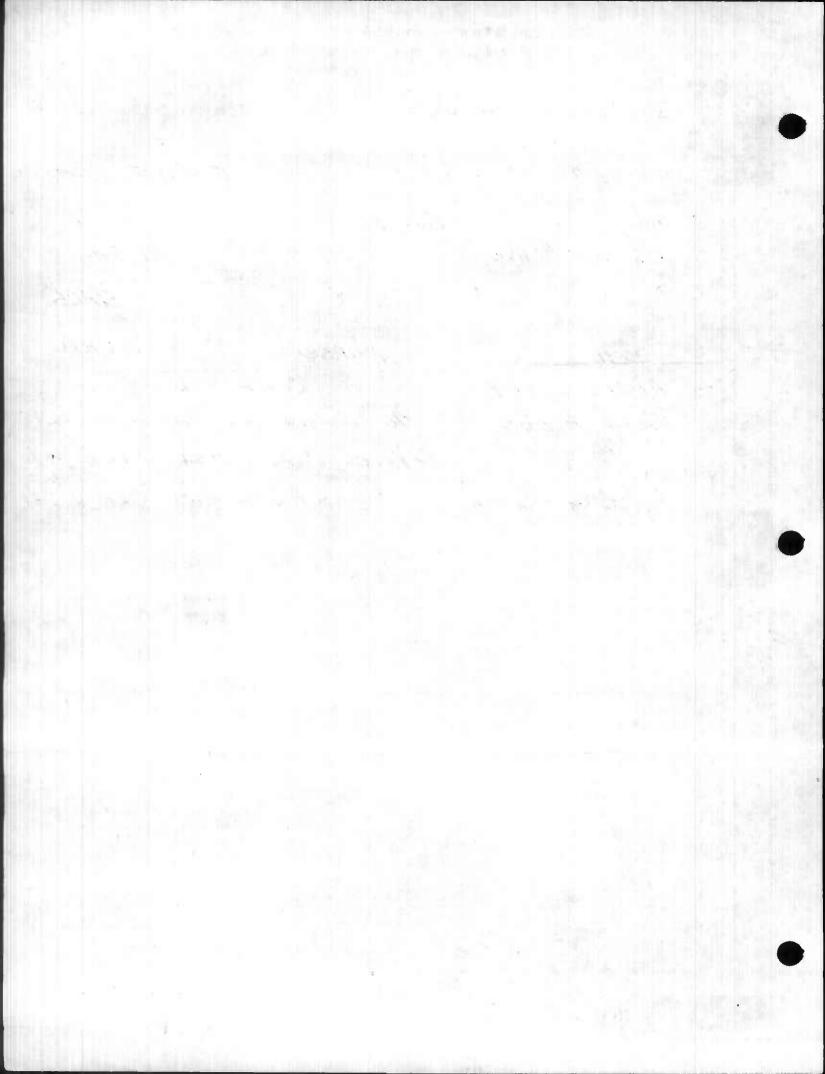
Registrar

OPHELLA

GRAV,



State Registra



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death AMENDED #10c G791 01-03-01 SS 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First Middle Last) Month 4e Fecility Neme (If act institution, give street and number) 09:30Pm 4b. City, Town, or Location of Deeth 4c. County of Death Howard County General Hospital Columbia, MD Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Dey, 6. Sex 1 M M 2□ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Months 60 Yrs England Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas Ž ☐ No Brentford Middle England Middlesex 10e Street and Numbe 10g. Citizan of What Country? ourt Justin Close 12. Was Decedent Ever in U.S. 13. W TW880G N England 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 ☒ No If Yas, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Consultant Housing Authority 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Walter Hughes Kitty Lowder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informant's Name/Relationship (Type, Print) Bernard Gorda/Brother-in-law 9577 Battler Court Columbia. MD 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) Date 20c. Location - City or Town, Stata Metro Crematory Inc. 1-3-01 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of MD, Inc. Thomas Gregor 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Ceuse (Finel disease or condition rasulting in daath) of Unknown y ear Dua to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings eveilable prior to complation of causa of death? 24a. Was an autopsy 1 🗆 Yes 2 No 1 ☐ Yes 2 No

Physician /Medical Examiner

permit. Pages 1 and 2 shi Department of Health end Important: If itam 27 1s m any injury or other traum once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

r than "natural", or heme 23s or 28s-f ahow the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health end Mental Hyglene.
int: If item 27 is marked other than "natural", or file

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records,

or Attending Physician:

After

after death.

Director

Funeral

þ

Completed

with the Maryland

Examiner pue physicien Physician/Medical the attending phed for use as signed by the py Be Completed pege 2 certificate has Medical Certification: To Director: / To the Hospital or Attan

25. Was case referred to medical 1 Yes 2 No

4 Homicida

29e. Certifier

27. Manger of Death 1 MNatural 2 Accident 5 Pending investigation 6 Could not be 3 ☐ Suicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

Hospital: Inpatient 28b. Time of

2 ER/Outpatient 3 DOA Injun

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury at Work? 1 Yes 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

2 No

26. Place of Death (Check only one)

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

Rd Ellust Coy MO

28d. Describe how injury occurred

29c. License number

29d. Date signad (Month, Dey, Year)

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 950 MO 90

31. Date filed (Month, Dey, Year)

29b. Signature and titla of certifier

32. Registrar's Signature

w

Registrar

State

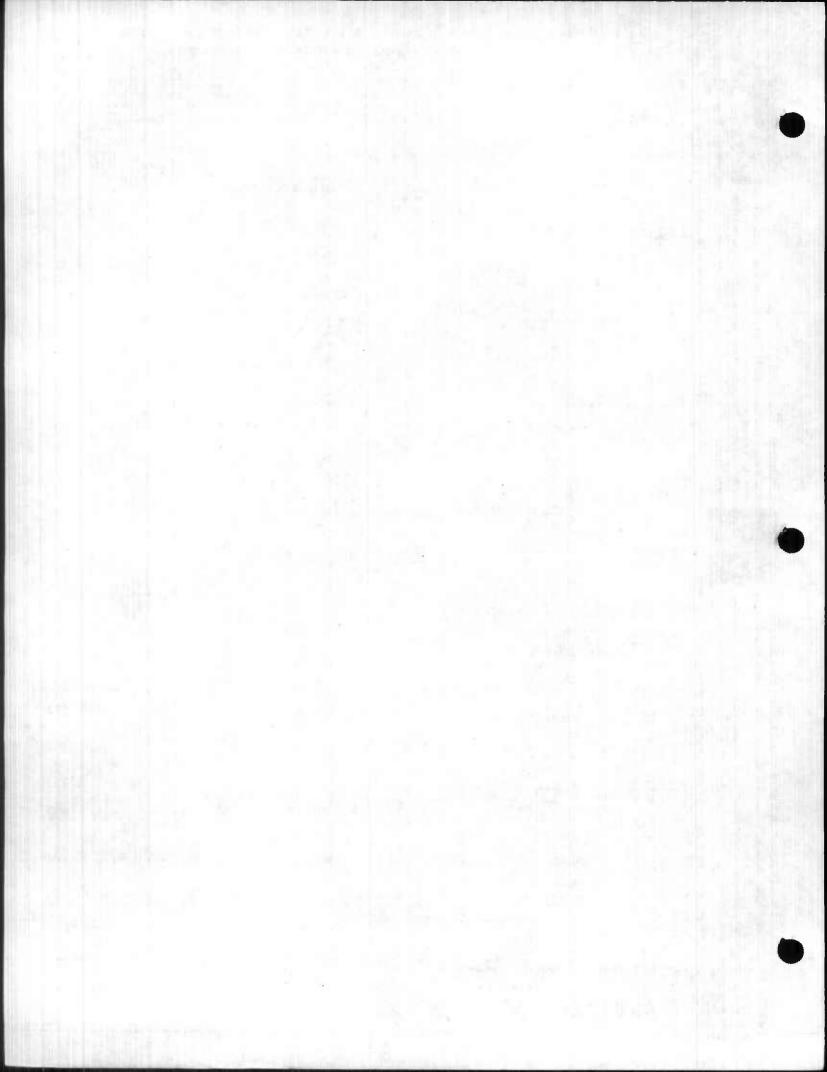
011-2-11

State of Maryland / Department of Health and Mental Hygiene 1 4 2 0 3 1

			Certificate of	Death	Re	g. No.) bot				
	Decedent'a Neme (First, Middle, Last)		STATE OF		2. Data of Death Month	Day	Year	3. Tima of	Death		
Physician /Medical	Norma Jager Hecker		Block Control		December		2000	7:18	am		
Examiner	4e Facility Neme (If not instifution, giva street and n	um <i>ber</i>)		4b. City, Town, or L	ocation of Death	4c. County o	of Death	- 4-5			
	Anne Arundel Medical C			Annapol:		Anne					
Funeral Director	5. Social Security Number 6. Sex 1 M 2XXF	7. Age (In yrs. lest b	Yrs. If Undar 1 Yaa Months Deys		8. Data of Birth (Month, Day, Sept. 7,	ata of Birth South, Dey, Year) out. 7,1927 9. Birthplece (State or Financial Country) 111inois					
9	Usual Residence of Decedent 10a. Stete 10b. County	100 On To	wn or Location				40		CALLED		
Manyla H show	MD Anne Arundel		10d. Inside City 1 ☐ Yes 2								
h with the Mar 3a or 28a-f al 1b notified	10e. Street and Number 964 Melvin Road		1403	10	10g. Citizen ot Whet Country? USA						
1215-0036 within 72 hours after death with the Manyland ene. than "natural; or items 23e or 28e-f show he Medical Exeminer must be notified at ompleted by Funeral Director	Armed F	2 \ XNo ive	13. Wes Decedent of ff Yes, specify Cu		ecify Yes or No- Rican, etc.)		- Americe c, Whita, e Wh				
15-003 72 hours "natural", polical Exe	15. Decedent's Education (Specify only highest grade completed) 164	a. Decedent's Usuel Occu (Give kind of work done lifa. DO NOT use ratir	upetion a during most of work	ing 1	6b. Kind ot Bus	Iness/Indi	ustry			
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours af t Health and Mental Hygiene. Item 27 Is marked other than "natural", or other traumatic event, the Medical Exam To Be Completed by F		(1-4or 5+)	'lifa. DO NOT use ratir Secretary	ed)		J.S. Nav	val A	cadem	У		
ind 2 be filed tal Hygid d other event, II	17. Fether's Neme (First, Middla, Last)			18. Mother's Nam	e (First, Middle, M	laiden Sumeme	,)				
ylan Mental Ment	William Frederick Jager	ienst									
Maryland d 2 should be file th and Mental Hy 7 Is marked oth traumatic event To Be (19e. Informent's Neme/Relationship (Type, Print)	19	b. Mailing Address (Stree	at and Number or Rui	el Route Number,	City or Town, S	Stete, Zip (Code)			
and 2 and 2 n 27	John E. Hecker (Husband		64 Melvin R	oad, Annaj	polis, MI	21403					
0 00 = 5	20e. Method of Disposition 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removel from 4 ☐ Donetion 5 ☐ Other (Specify)	Stete	of Disposition (Name of ery, crematory or other pl and Veteran	-	01/03	Oc. Location - C	1				
Baltim pamit. Par Departman Important: sny Injury :	21. Signeture of Funaral Sarvice Licensee	1		rass of Facility Y Funeral	Home, P.		- 01.4		7/53		
	23a. Pert1. Enter the disaesa, or complications the shock, or heert teilure. List only one ceuse on	ceused the deeth. Do		ely Avenue				Approximete)		
Physician /Medical Examiner	shock, or heeft tellure. List only one ceuse of Immediate Cause (Final disease or condition resulting in death)	Cen d	rác C	Zever &			1	Intervel Betw Onset end D	reen Peeth		
è		Due to (or es e	e consequence of):	1							
n and tal-transit	Sequentially list conditions	Dua to (or as e	consequence of): /	uwe	<u> </u>						
60, be execut clan and burtal-tra	1 course. Litter chostnying										
reflicants and physics are the Medic	Cause (Disease or injury that initiated evants reaulting in death) Lest	Dua to (or as a	consequence of):				1				
death death of tor after	Pert II. Other eignificant conditions contributing to	death but not resulting	in the underlying cause of	iven in Part I.	23b. Dld tot	pacco use con	tribute to	the cause o	of death?		
Is, P.O. Box we that the death or igned by the attend be detached for us by Physician/	Caroney a	nten	Due	مما				ably 4@1			
been a should been a should	by serliged					ilable prior to apletion of co	0				
I Re lass tas has page 2					1 ☐ Ye	s 210 No	1 🗆	Yes 2	No		
Vittal I iddan: Th certificats rector, pay	25. Wes cese reterred to medical exeminer?				h (Check only one	9)					
T TO T	1 Yes 2 No Hospitel: 1 □	Inpatient 2 ER/O	oupatient SE DOA		ome 5 Resider)			
E Bull	27. Menny of Deeth 1/ Neturel 5 Pending 2 Accident invastigation	ot Injury oth, Dey Year) 28b.	. Time of tnjury M 28c. Inj	ury et ork? ☐ Yes 2 ☐ No	28d. Describe ho	8d. Describe how injury occurred					
Division of the Hospital or Attending P within 24 hours after death. To the Funeral Director: After toompletely filled in by the funeral Medical Certification:	3 Suicida 6 Could not be determined 28e. Plec built	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)									
he Hospital in 24 hours he Funeral pietely lifted edical Co	29a. Cartifier (Check only one) **Certifying Physician: To the 2 Medical Examiner: On the end me)		
Med Med	29b. Signature and time of certifier		29c. Licar	nsa number	29	d. Date signad	(Month, E	Pay, Year)	2 10		
. (I What		7	38400	3	12-1	01				
10	30. Name and address of person who completed can William Behrens, M.D.,			polis. MD	21401						
State		Registrer's Signeture	las de	TOTTO, ID							

DHMH 16 Rev 6/95

ORIGINAL



/Medical Examiner

Examiner

physician and the burial-transit Physician/Medical 88 signed by t hes page is certificate h director, page Certification:

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Completed

Be

10

edicai

Records, Division of Vital Physician: After this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funera

BOZENNA HORODOWICZ

Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es a consequance of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were eutopsy findings evailable prior to completion of causa of deeth? 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 27. Menner of Deeth 28d. Describe how injury occurred injury at Work? 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physictan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, end due to the ceuse(s) end manner stated. 29e. Certifier (Check only one)

State Registrar

DR. TARIO MAHMOOD 31. Dete filed (Month, Day, Year)

JAN 03 2001

29b. Signeture end title of certifier

2300 DULANEY VALLEY RD. 32. Begistrer's Signeture

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

ORIGINAL

DHMH 16 Rev 6/95

3. Time of Death 1:00 AM

December 29, 2000

4c. County of Deeth Baltimore

9. Birthplece (Stete or Foreign 8. Dete of Birth (Month, Dey, Year) Poland

April 28, 1951 10d. Inside City Limits

1 ☐ Yes 2 No

10g. Citizen of What Country? U.S.A.

14. Race - American Indien, Black, White, etc.

White

16b. Kind of Business/Industry

Nursing Home

20c. Location - City or Town, Stete

Baltimore, Maryland

21236

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

METASTATIC MELANOMA

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Approximate Intervel Between Onset end Death

29c. License number 29d. Data signed (Month, Day, Year)

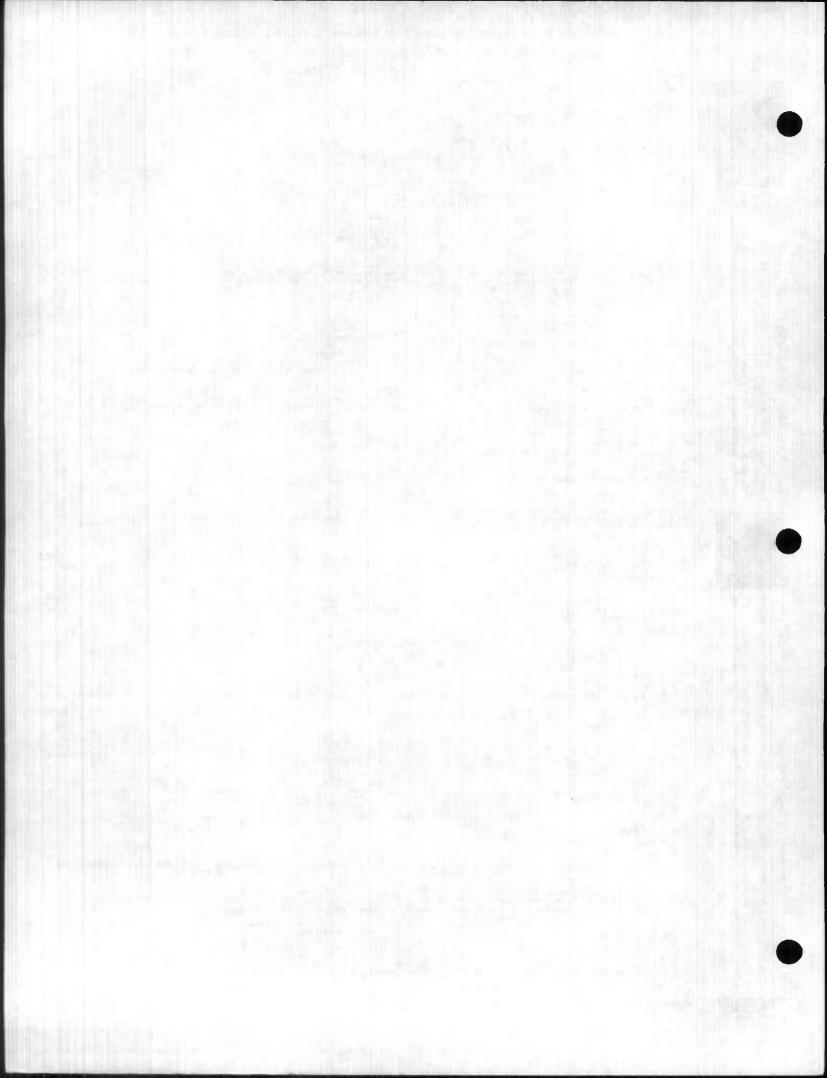
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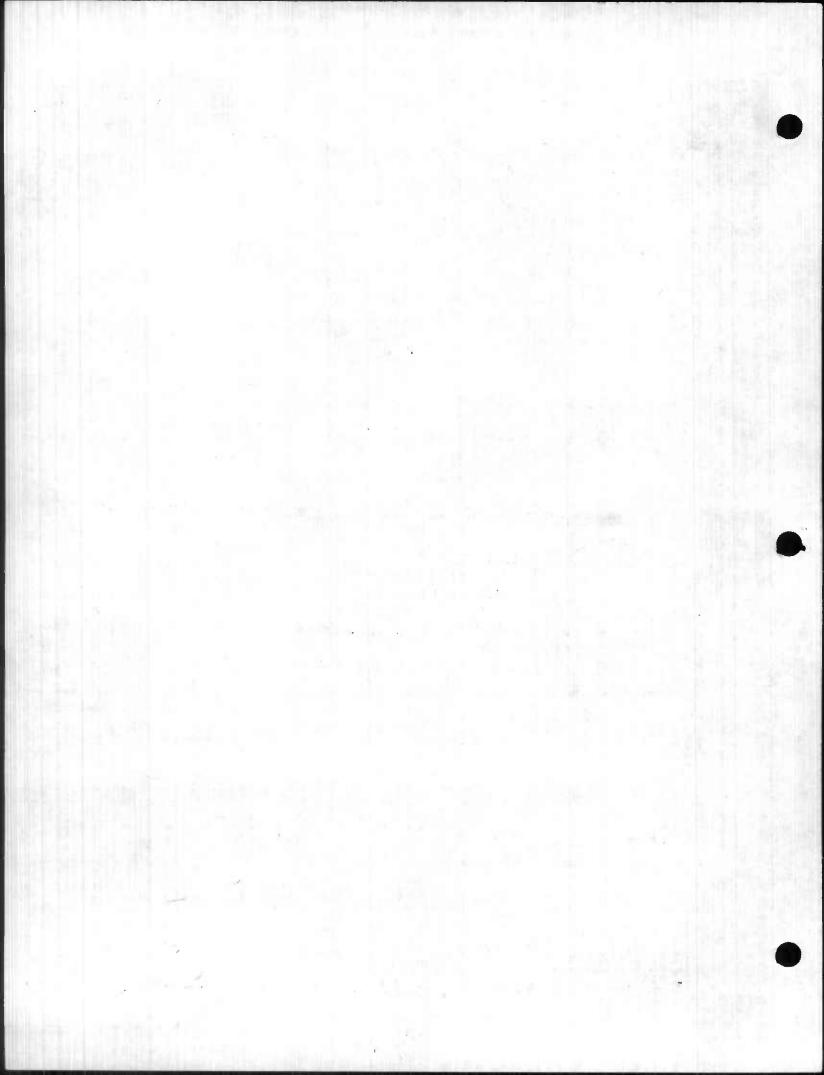
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 4 2 0 3 3

							C	ertifica	te of	Death		Reg. No.	U 4	2000		
	H		1. Decedent's Name	a (First, Middle, La	ist)	- 74		AL S			2. Date of De	eath Dey	Yaer	3. Time of Death		
4	Physici /Medic		David W.	Haughey							Decembe		2000	11:14 A.M.		
	Examir		4a Facility Name (#	not institution, giv	e street and numb	er)				4b. City, Town, o	r Location of Deat	h 4c. Co	unty of Death	1		
			Good Samaritan Hospital Baltimore City N/A													
	Funeral Director		5. Social Security Number 213-52-5875 Usuel Residence of Decedent 6. Sax 10X M 2 F 57 7. Aga (In yrs. lest birthday) 57 Yrs. 7. Aga (In yrs. lest birthday) Fit Under 1 Year Months Deys Hours Min. 8. Date of Birth (Month, Day, Year) August 25, 1943 Mc								9. Birth Coo	rthplece (Steta or Foraign ountry) aryland				
	g tang	4	10a. Stete 10b. County 10c. City, Town or Location 10d. Inst										10d. Inside City Limits			
	the Mary 28a-f eh	ector	Md. N/A Baltimore City 10e. Street and Number 10f. Zip Coda								1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
	a 23a or	Funeral Director	2914 Montebello Terrace 21214 11. Marital Status 12. Was Decedent Evar in U.S. 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-								USA	USA 14. Race - Amarican Indian,				
21215-0020	n 72 hours after death with the Maryland "naturel", or hams 23s or 28s-f ehow solicel Examinat mass be notified	by	11. Marital Status 1 Never Merric 3 Widowed	ed 2 Merried	Armed Forces? If Yes			If Yes, sp	2 No	Specify:	specify fas of No arto Rican, etc.)	- 4	te			
5-0	72 ho	eted	(Spec	15. Decedent's E	ducation ada completed)	on 16a. Decedent's Usual Occupetion (Give kind of work done during most of wo				orking	16b. Kind	of Business/I	ndustry			
121	within than	Completed	Elementary/Secon		College (1-4pr 5+)											
	filed with Hygiene. ther ther		6th Grade 17. Father's Name (осре	ependent Never Worke			ame (First, Middle	. Maiden Su	N/A	·		
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Maryland	2 should be and Mental • marked o	2	19a. informant's Ne				19b. Ma	iling Addre	ss (Street		Rural Routa Numb		own, Stete, Z	ip Code)		
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altimore	Pages nent of I int: If He iry or o			□ Cremation 3 L 5 □ Other (Special	Removal from Sta	100		d Ceme			1/3/01	Balti	more M	laryland		
Balt	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than eny Injury or other traumatic event, the Handa.		21. Signature of Fu	7 .	nsee Christin	na L. Hi				Ruck,				04044		
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П	Examiner		resulting in death)		a	Due to (or	es e cons	equenca o	f):	. (1	,		
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Ä	The law ate has page 2	mo									10	Yes 2	No 1	1□ Yes 20 No		
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	o the	M	29b. Signeture and	title of certifier	one manno			2	9c. Licens	se number		29d. Date s	igned (Mont/	h, Dey, Year)		
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	6		30. Nama and addre	ess of person who	completed cause of		23a) (Tvn	e. Print)	OA	22	1000	287	2	1 1		
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iner				iva street and num	iber)						tion of Death		unty of De	ath	
al or	5. 5	Social Security N	860		7. Age (In yrs. 62	lest birthdey) Yrs.	If Undar 1 Y Months D	ear I	TUnder 24 Hours	Hrs. 8	Date of Birth (Month, Day 08/01/	Year)	9. B MI	lirthplac Country	ce (State or Fo
		ual Rasidence of a. State	f Decedent 10b. County		10c Cit	y, Town or Lo	cation	19						104	. Inside City L
20														100	1 ☐ Yes 2
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	-		ame/Relationship			19b Mailir	ng Address (Si	troot and					wn State	Zin C	nde)
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edical Certification: To Be Completed by Physician/Medical Examiner	Se if & cee Ca the res	eguentially list coany, laeding to in use. Enter Understally list coany, laeding to in use. Enter Understall list as (Disease or at initiated events sulting in death) I till. Other significant lill.	onditions, nadiate strying injury s. Last	Hospital: 1 In	Due to (or Due to (or Service) ath but not res	or as a consequence of a conseque	uence of): Limburguence of): Surall Inderlying ceus at 3 DOA 28c.	2 Other: Injury a Work? 1 Ye	26. Place of 4 ☐ Nursi	ng Home	24a. Was a perfoi	an autopsy med? as 2 4 7 as 2 5 7 an injury or one of the control of the contr	24th	b. Were avail compored de 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	he cause of d bly 4 Uni e autopsy find able prior to oletion of ceus ath?
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ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Year Catherine H. Hedemann 4:05PM 31 Dec 7000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Lorien Frankford Ave. Baltimore If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 1 M 2 KF Days Hours 83 Yrs. 218-05-4171 March 27, 1917 Maryland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 20 No Baltimore Maryland Essex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 978 Punjab Circle 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S Armed Forcas? 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 ₩idowed 4 Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 6th Homemaker Domestic 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumeme) Walter Maciejewski Maryanna Drozd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Anna C. Sorrentino / daughter 4 Old Ruhl Ct. Freeland, Maryland 21053 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 01/03/01 Baltimore, Maryland Holy Rosary Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231 Approximata intarval Batween Onsat and Death Part 1. Enter tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MOS Immediate Ceuse (Final disaasa or condition resulting in deeth) Dua to (or as a consequence of) Sequentially list conditions, if any, leeding to immadiate cause. Enter Undarlying Cause (Disaasa or Injury Dua to (or as a consequance of) that initiated avants rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RMCNTIA 24b. Were eutopsy findings available prior to complation of cause of death? 24a. Was an autopsy 1 Yas 2 No 2 No 1 Yas 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accidant 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 Suicida 6 Could not be

Hedram, Catherine

s the burial-trans attending pl 2 signed b After this certificate has funeral director, page 2 To the Hospital
within 24 hours a
To the Funeral Completely filled

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

r than "natural", or items 23s or the Medical Examiner must be

d 2 should be filed within 72 hours after death vit and Mental Hygiene.
7 Is marked other than "natural; or items 23, traumatic event, by Medial Est prior man

permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event once.

Physician /Medical

Examiner

Examine

Physician/Medical

Completed by

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Certification:

edicai

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

with the Maryland

Director: A

29b. Signatura and titla of certifiar

4 Homicida

29e. Certifier

Certifying Physician: To the best of my knowledga, daath occurred at the tima, deta and place, and dua to the cause(s) end mannar es stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. Masolew macalrey 200

29c. Licansa number

29d. Data signed (Month, Day, Year) 2,2000

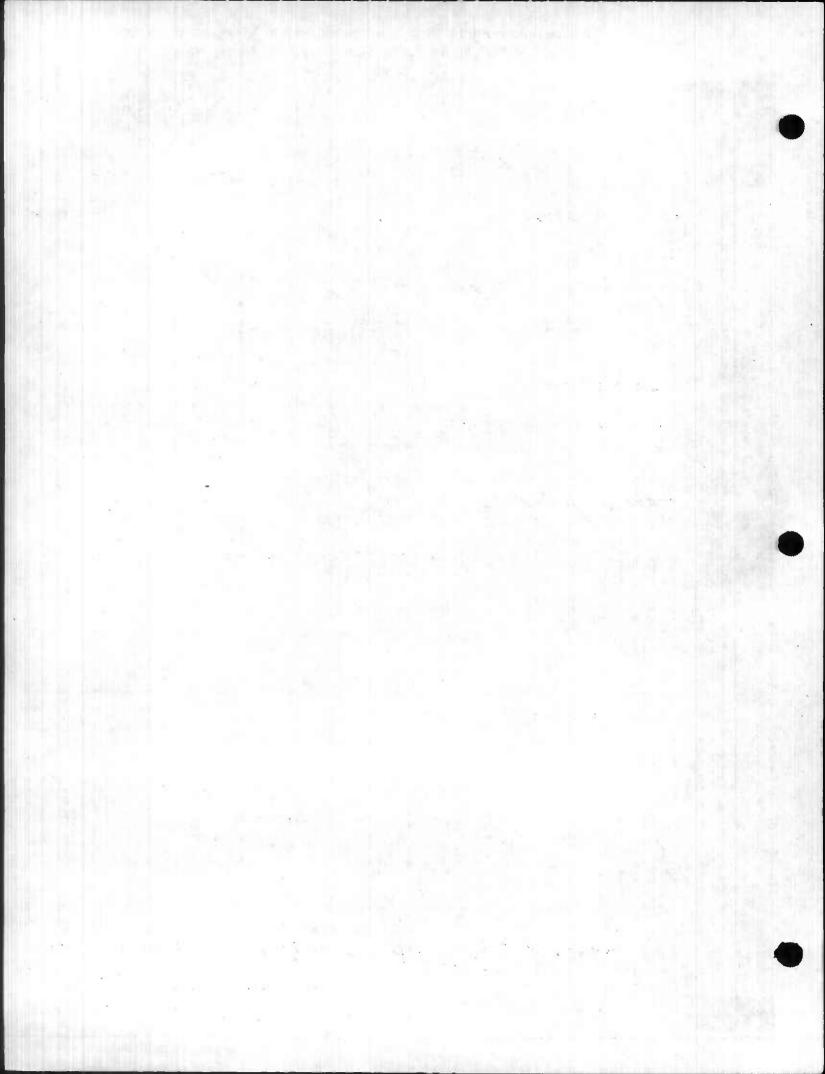
30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

MICNABNEY MATTHEW 5505 HOPKINS BANIEN

State Registrar 31. Data filed (Month, Day, Year) JAN 0 3 2001 32. Registrar's Signatura

ORIGINAL

28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death TH HARRIGAM DECEMBER Dey TH Year OWEN 1:30 Pm 2000 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE RANDALLSTOWN CENTER. HOSFITAL NORTHWEST If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) unk 1X M 2 F 71 Yrs. JUNE 15, V.I. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No NA TORTOLA 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? BRITISH VIRGIN ISLANDS 14. Raca - American Indian, NA NORTH SOUND VIRGIN GORDA 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck White etc. 1 ☐ Yes 2 ♠ No If Yes, Give 1 Never Merried 2 Married Specify: INDIAN 1 Yes 2 No Specify: 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 7th NA BOAT CAPTIAN SHIP 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) JOSEPH HARRIGAN ISA HARRIGAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 3302 PEDDICOAT COURT WOODSTOCK, MD DEAN O. HARRIGAN (SON) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Mother (Specify) SHIP OUT 1/6/01 NORTH SOUND PUBLIC CEM. TORTOLA, BRITISH V.I. 21. Signature of Funeral Service License 22. Name and Address of Fecility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217 234. Peri 1. Enter the disease, or condications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) TINEUMONIA. Due to (or es e consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In death) Last Due to (or es a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ESOPHAGUS. 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Director

Funeral

by

Completed

Be

Funeral

Director

show

r than "natural", or items 23a or 28a-f the Medical Examiner must be notifie

the Maryland

filed within 72 hours after

Hygiene.

Pages 1 and 2 should be from of Heelth and Mental I

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21215-0020

Baltimore, Maryland

buriel-transit phys. 980 signed by the atte phode page 2

The law requires that the death certificeta be executed

Box 68760,

P.0.

Records,

Division of Vital or Attending Physician:

After this

24 hours after deeth.

Hospital

Within 2

filled in by

completely

29a. Certifier

(Check only one)

Examiner Physician/Medical Completed by Be Medical Certification: To

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. CARCINOMA

completion of cause of death? 2 XN0 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical axaminer? 1 ☐ Yes 2X No Hospitel: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Neturel 2 Accident 5 Pending investigation

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? t ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner steted.

29b. Signature and file of a etition oncy

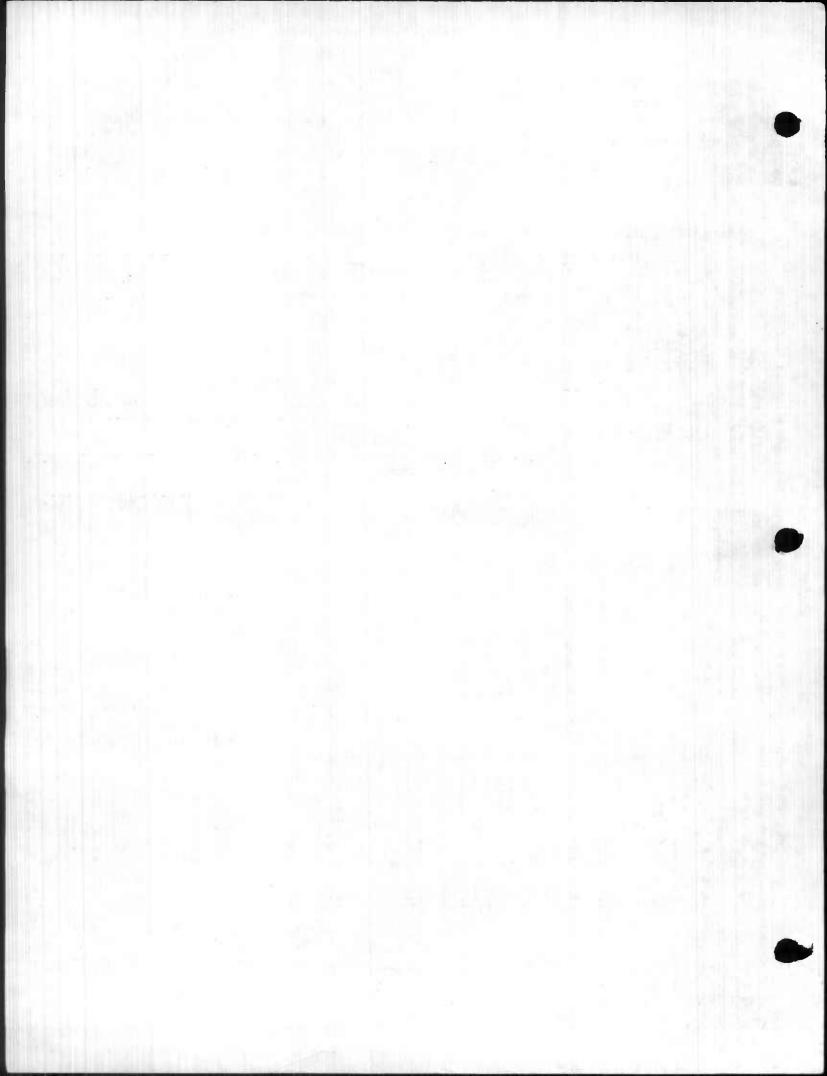
29c. License number

29d. Date signed (Month, Day, Year) ECEMBER 2000

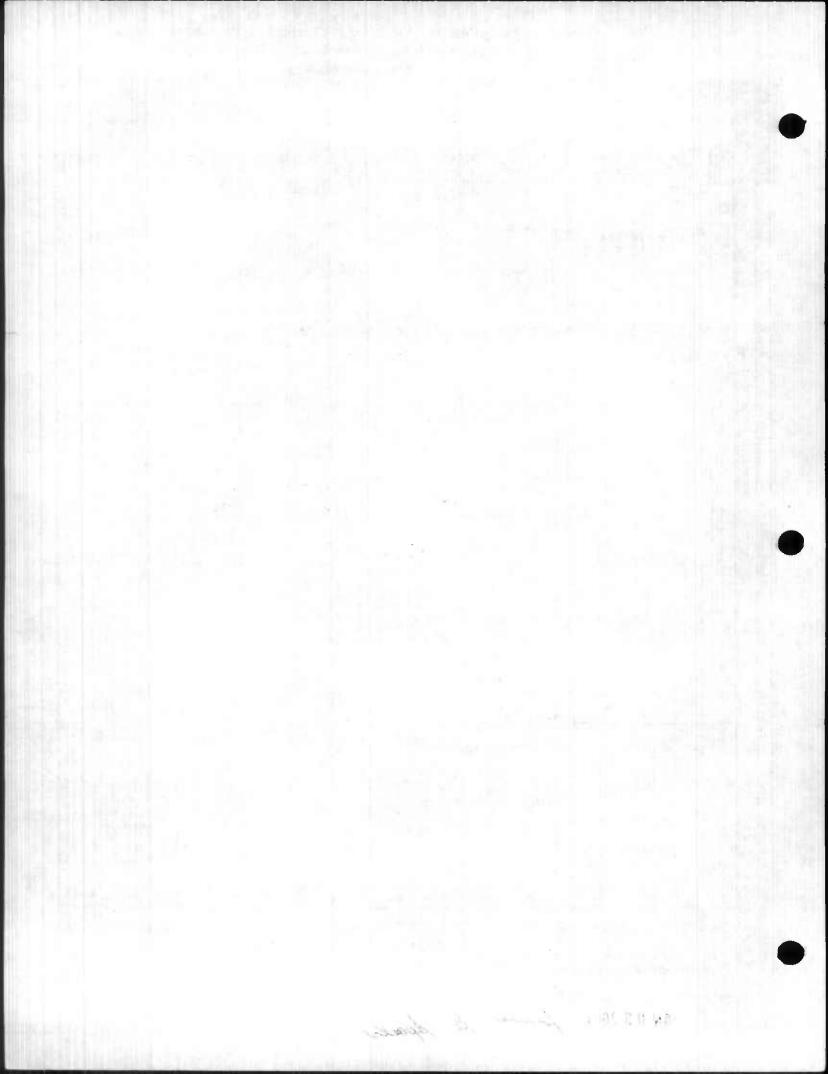
Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

VERAHALLI m 31. Dete filed (Month, Day 32. Registrer's Signature

State Registrar



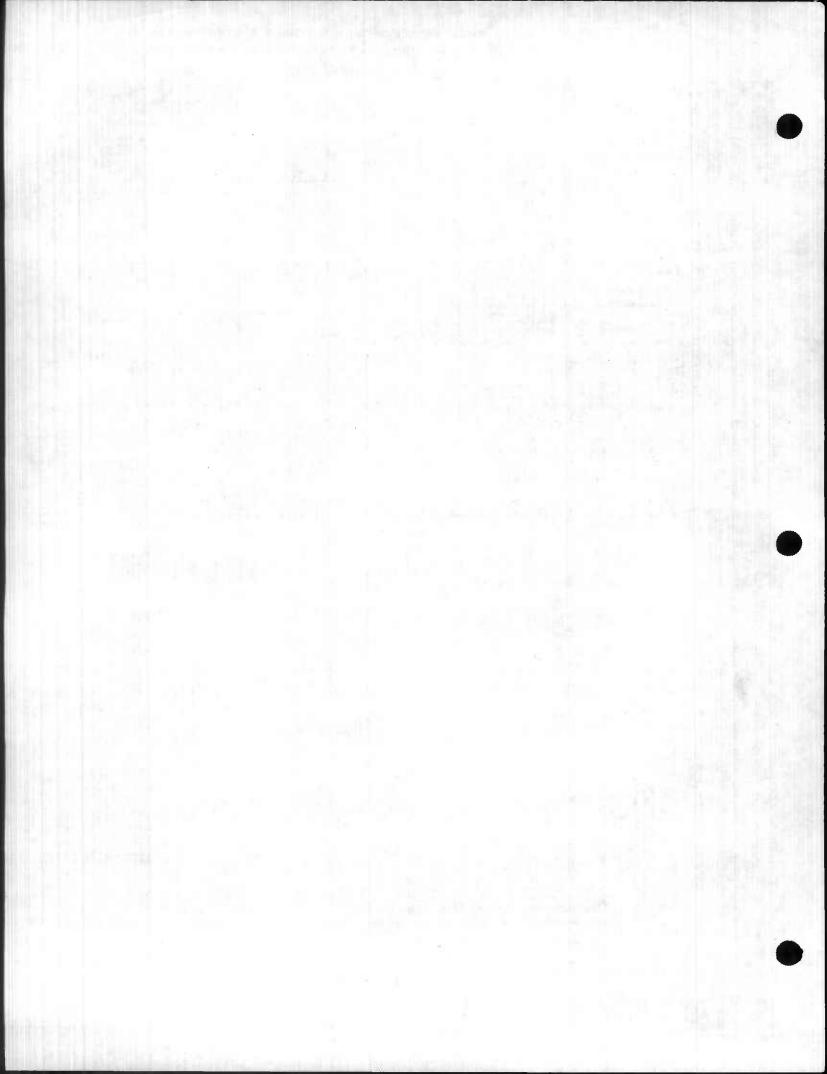
cian lical	1. Decedent's Neme (First, Middl	(e. Last)		Certificate of		Reg.	No.	4/	3. Time of Death
	MABLE	IMLER					Dey 31 20	Yeer 000	5:00 AM
iner	4a Facility Neme (If not institution CATON MANOR NU				4b. City, Town, or Loca BALTIMORE	tion of Deeth	4c. County		
ı	5. Sociel Security Number 227–24–8289	6. Sex 1 M 2 F	7. Age (In yrs. last	birthdey) If Under 1 Yea Months Days	If Under 24 Hrs. 8 Hours Min.	Dete of Birth (Month, Dey, Yean, 15 1			ace (Stete or Foreig ry) inia
	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, T	own or Location				10	d. Inside City Limit
otor	Md.	n/a	Bal	ltimore					1 Yes 2 N
Funeral Director	10e. Street and Number 4120 West Bay	Court		10f. Zip Code	21225		Citizen of V	Vhat Count	ry?
and the paradilloc ac	11. Maritel Status 1 Never Married 2 Man 3 New Midowed 4 Divorced	Armed Fo ried 1 ☐ Yes If Yes, Giv	2 No	13. Wes Decedent of If Yes, specify Cul	Hispanic Origin? (Speci ban, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	Blac	e - America k, White, e whi	NC.
		t's Education st grede completed)	1	6a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	during most of working	166	. Kind of Bu	siness/Ind	ustry
ı	Elementary/Secondery (0-12)	College (1	-4or 5+)	Home Maker	50)		Home	e Own	er
	17. Fether's Neme (First, Middle,			THOMAS THE STATE OF	18. Mother's Name (i	First, Middle, Mai	den Sumem	10)	
	Fred	Kleir			Ida		elton		
	19a. Informant's Neme/Reletions Lola C. Martel	ship <i>(Type, Print)</i> (Daught		19b. Mailing Address (Stree					
ŀ	20a. Method of Disposition	(Daugiii	20b. Plece	234 Turnwood of Disposition (Name of			Le, Mo		
	1 Burial 2 Cremation 4 Donetion 5 Other (S		State	en Mount Ceme			altimo		
	21. Signeture of Funeral Service	COH	enrik		y-Polyniak				
1	23a Párt1. Enter the diseese, or hock, or heart failure. List	complications that a	nuned the death. [Do not enter the mode of dy	Patapsco Zing, such es cardiac or i	ve. Balinespiratory arrest,	timore	MD	Approximate Intervel Between
	Jock, of Healt failule. List	Only One Cause Of the	wui iii 16.	/					Onset end Death
	Immediate Ceuse (Finel disease or condition resulting in death)	a		Diubete					lakeron
-	resuming in obating		Due to (or es	e consequence of):					
CXamme		b	Due to for on	a consequence of				- 1	
3	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es	a consequence of):					
	Cause (Disease or injury that initiated events resulting in deeth) Lest	c	Due to (or es	e consequence of):					
2	resulting in deetily Less	d							
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		*		Ψ.					
	Pert II. Other eignificant condition	one contributing to de	eath but not resultin	g in the underlying cause g	iven in Pert I.				the cause of deat
	7	hereing to de	ath but not resultin	g in the underlying cause g	iven in Pert I.		cco use cor 2□ No		
•	7	1	ath but not resultin	g in the underlying cause g	iven in Pert I.		2□ No	3 Prot	
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State of Maryland / Department of Health and Mental Hygiene 0 4 2 0 3 8

pysician Medical de Figure 100 de 100		A Venue 12 Was Decedent Evared Forces of Year or Detes: 2 Was Decedent Evared Forces of Year or Detes: 1 Yes 2 No Wide of Yes 2 No Wide of Year or Detes: 2 Was Decedent Evared Forces of Year or Detes: 3 Yes 4 Year or Detes: 4 Yes 5 Year or Detes: 5 Year or Detes: 6 Yes 6 Year or Detes: 7 Yes	In yrs. last bit 4 Oc. City, Tow Balti er in U.S. 16e S 20b. Place of comments WOOO	Ctn. rthday) ff Unc. Month rrs. Month more 10f. 2 13. Wes Decifi Yes, si 1 Yes Decedent's U. Give kind of life. DO NOT Gelf-en D. Meiling Addres 23 13t of Disposition (Any, crematory of lawn (22. Name) WM. C	Zip Code 2121 cedent of Hipperity Cube 2 2 No sel Occupe work done of ruse retired, mploy ess (Street a th St Name of or other place cemet	ispenic Origin? (S in, Mexicen, Puer Specify: etion during most of wo red 18. Mother's Nat Marth and Number or Re creet N ee) ery Ol-	Dre 8. Dete of Bir (Month, Da O 7 - 0 2) 1. Detection of Bir (Month, Da O 7 - 0 2) 1. Decity Yes or No o Ricen, etc.) 1. Decity Yes or No o Ricen, etc.) 1. Decity Yes or No o Ricen, etc.) 1. Decity Yes or No o Ricen, etc.)	Dey 29, 20 1 4c. County N 2 14c. County N 2 16c. County N 2 16c. Citizen of N 2 14c. Race Blace Specify 16b. Kind of Br. Self-e Maiden Suman SCO er, City or Town, arlotte 20c. Location-Woodl	9. Birthplece (State or Forei Country) VA 10d. Inside City Limi Yayes 2 n Whet Country? Per - American Indian, ck, White, etc. Black usiness/Industry employed ne) tt State, Zip Code) 2290 esville, VA city or Town, State awn, MD
Medical daminer 4e F. C.	Genesis Elder Genesis Elder Cocial Security Number COCIAL Security N	AVENUE AVENUE 12. Was Decedent Evamed Forces? 1	ewood (In yrs. last bi 4 10c. City, Tow Balti er in U.S. 16e 20b. Plece comete Wood	Ctn. rthday) ff Unc. Month rrs. Month more 10f. 2 13. Wes Decifi Yes, si 1 Yes Decedent's U. Give kind of life. DO NOT Gelf-en D. Meiling Addres 23 13t of Disposition (Any, crematory of lawn (22. Name) WM. C	Zip Code 2121 cedent of Hipperity Cube 2 2 No sel Occupe work done of ruse retired, mploy ess (Street a th St Name of or other place cemet	Baltimo If Under 24 Hrs Hours Min. 2 ispenic Origin? (S in, Mexicen, Puer during most of wo red 18. Mother's Nat Marth and Number or Ri creet N set Section Acres Se	Dec. Location of Deeth Dre 8. Dete of Bir (Month, Da 07-02 Decity Yes or No o Ricen, etc.)	29, 20 4c. County N 4c. County N 10g. Citizen of V USA 14. Rac Blac Specify 16b. Kind of Br Self-e Maiden Suman SCO er, City or Town, arlotte 20c. Location Woodl	9. Birthplece (State or Forei Country) VA 10d. Inside City Limi Yayes 2 n Whet Country? Whet Country? Black usiness/Industry mployed ne) tt State, Zip Code) 2290 esville, VA city or Town, Stete awn, MD
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30. N	1000A								Baltmore 212

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Day Month Year 12 NOON ELIZABETH JOHNS DECEMBER 29 2000 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore r If Under 24 Hrs. 8 Bon Secour Hospital 7. Aga (In yrs. last birthday) If Under 1 Yeer 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) Hours Min. 1 M 2 F Months Days 12 86 02 M.D. 218-01-8754 Usual Rasidence of Deceden 10d. Inside City Limits 10a Stata 10b Counts 10c. City. Town or Location 1X Xas 2 □ No NA Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A. Street Apt E 21216 2304 Winchester 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 □ Nevar Married 2 □ Married 1 Yas 2 No Specify: 3℃Widowed 4 Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) Elementary/Secondary (0-12) Collega (1-4or 5+) Seligman & Hite Dental Lab. 9th grade Dental Hygenist 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nema (First, Middle, Last) Clifton Goynes Mary Ferguson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 5303 Chrysler Ave, Baltimore Md Clifton H. Johns-Son 21207 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Manufal 2 Cramation 3 Ramoval from State Donation 5 Othar (Specify) Arbutus Memorial Park 1/5/01 Arbutus, Md 22. Nama and Addrass of Facility March F/H West 21. Signature of Funeral Service Licensee 23a Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shocks, or heart failure. List only one cause on each limit Baltimore Md 21215 Approximata Interval Batween Onset and Deat Immediar Causa (Final disaasa or condition rasulting in daeth) Dua to (or as a consaguanca of) Dua to (or as a consequence of) Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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Hospital of 124 hours e To the Hospital within 24 hours or To the Funeral Completaly filled

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The lew requires that the death certificate be assouted

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12 should be find and Mental Find marked of

permit. Peges 1 and 2 st Department of Health and Important: If them 27 is nany injury or other traum

Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaase or injury that initiated events rasulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying carts given in Part I.

1 Department 2 ER/Outpatient 3 DOA

28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings eveilable prior to completion of cause of death?

1 Yas

1 Yas 2 No

26. Placa of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify)

28c. Injury at Work? 28d. Dascribe how injury occurred 1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year)

30 Nama and eddrass of persol who completed causa of daath (Itam 23a) (Type, Print) MPIN

Hospital:

5 Pending invastigation

6 Could not be datarmined

State

31. Dete filed (Month, Day, Year)

25. Was casa rafarred to medical axaminar?

1 Yes

1 Natural
2 Accident

3 ☐ Suicide

4 \ Homicida

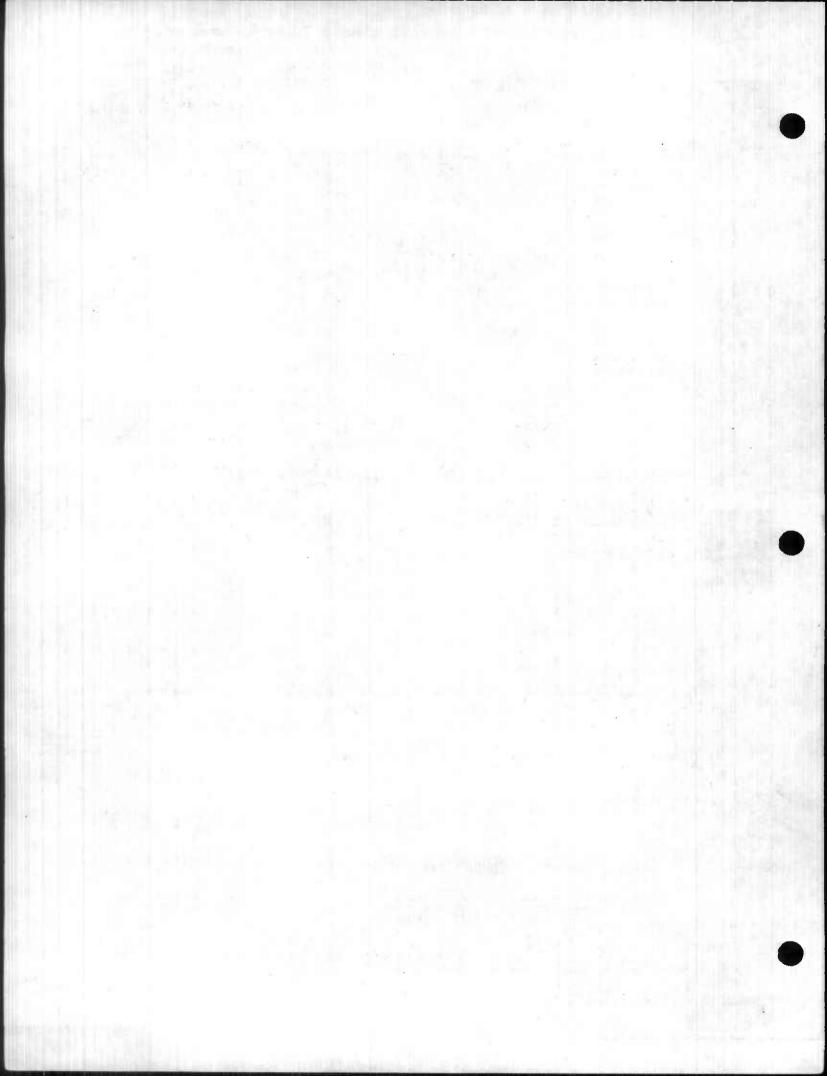
Manner of Death

2000 32. Registrar's Signatura

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DHMH 16 Rev 6/95

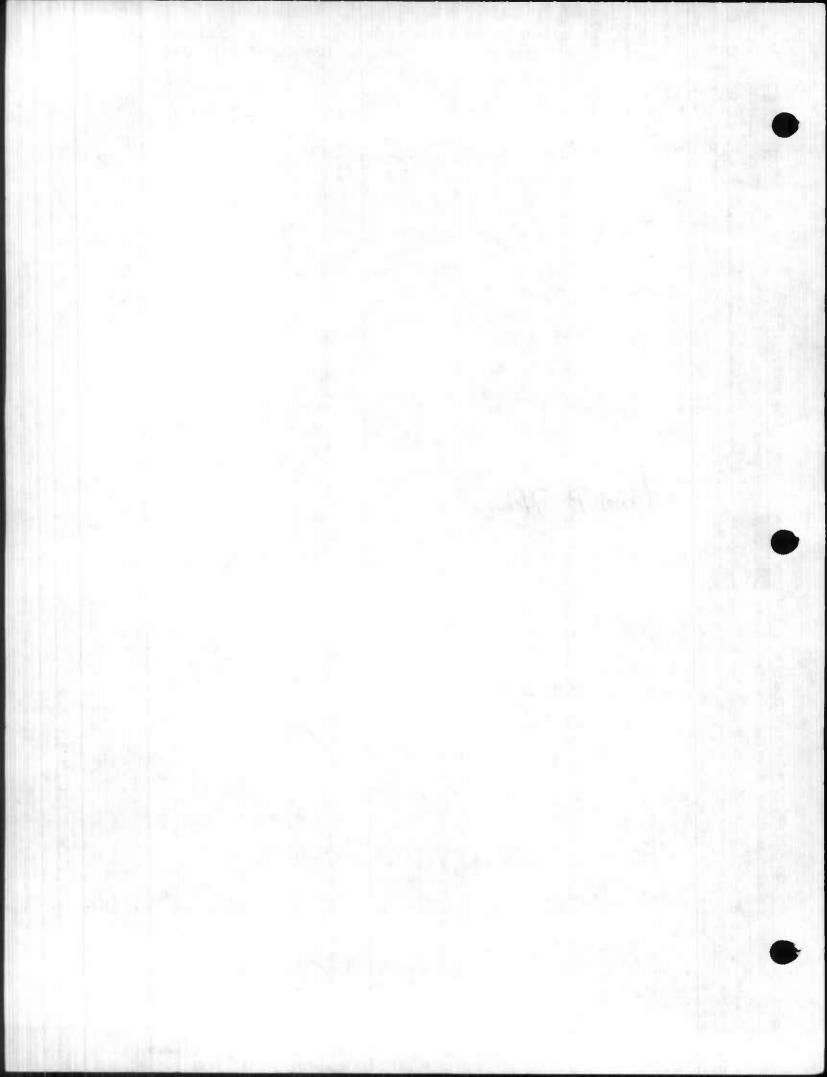
Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth Day **Physician** 10:30PM James December 31, Zooo /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Nama (If not institution, giva street and number) Examiner Baltimore RehablExtended Care Balto VAMC If Under 1 Yaar | If Under 24 Hrs. | 8. Deta of Birth (Month, Day, Year) 9. Birthplace (Stata or Foraign Country) 6. Sax 7. Aga (In yrs. last birthday) 5. Social Security Number **Funeral** 1⊠M 2□ F Yrs 220-12-6904 Director 74 26,1926 Maryland Usuel Rasidence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at NEWas 2 No Director Maryland Baltimore 101. Zip Coda N/A 10e. Street and Number 10g. Citizan of What Country? 23a or 4412 St. Thomas Avenue 21206 USA ifiled within 72 hours after deeth if Hygiene. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. NAS 2 No Nas, Giva Yaar or Datas: 1 Naver Married 2 Marriad Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: à White 3 Widowad 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16h Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed w Deperment of Health and Mental Hygien Important: If Nem 27 is marked other the any Injury or other traumatic evant. Roofer Roofing Company 8 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnema) Be Edwin W. James, Margaret Amelia Smallwood 2 19b. Malling Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Thomas Avenue Baltimore, Md
Dala 20c. Location City or Town, State Katherine James Wife 4412 St. 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Mathod of Disposition Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Othar (Specify) 01/04/01 Baltimore, MD Holy Redeemer 21. Signature of Funeral Service Licansae 21211 Inc. Burgee-Henss-Seitz Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of Gying, such as cardiac or respiratory and an armone, Marappoint and shock, or haar failure. List only one cause on each line. Intarval Batween Onsat end Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical lears Examiner Due to (or es a consequença of Examiner sician and buriel-transi Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseese or Injury that initiated evants rasulting in daath) Last Dua to (or as e consequenca of): attending physician Physician/Medical the Due to (or es e consequence of) 88 P.O. Box Part II. Other significant conditions contributing to death but not rasulting in tha undarlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Division of Vital Records, by 24b. Were eutopsy findings aveilable prior to complation of causa of deeth? 24a. Wes en eutopsy performed? Completed has 25 No 1 Yas 1 Yas 2 ON this certificata To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 20 No 10 28a. Data of Injury (Month, Day Year) 27. Manney of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred edical Certification: 1 DNatural 5 Panding Injury 1 Yas 2 No 2 Accident invastigation 6 Could not be determined 3 Suicide Place of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicida 1 Dertifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29b. Signature and title of or 29c. Licanse number 29d. Date signed (Month, Day, Year) Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) VAMC Rehab/ Extended Care orech Balto avid 31. Date filed (Month, Day, Year) 32. Règistrar's Signature State Registrar 2001

DHMH 16 Rev 6/95

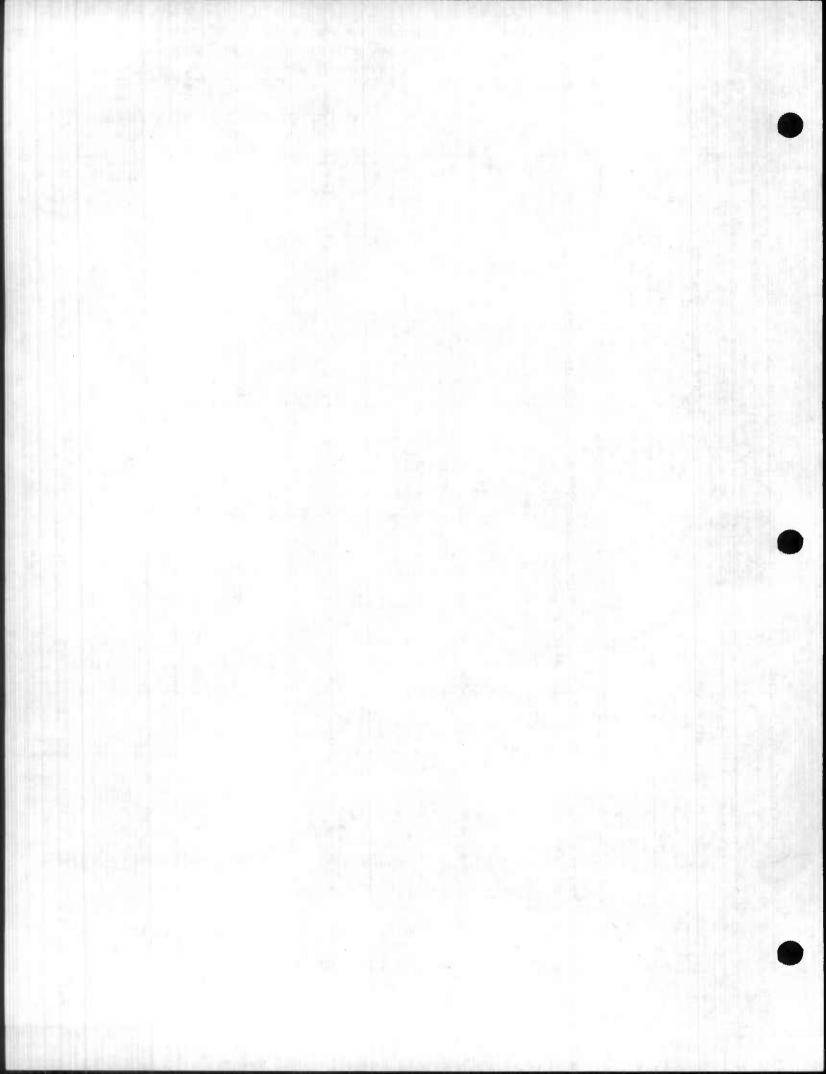


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM 20b G791 010301 SS I. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Tima of Death Month **Physician** Rae Belsinger Jeppi 5:45 PM December 29 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Center If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 7. Age (In vrs. last birthdev) 8. Dete of Birth (Month, Dey, Year) August 31,1910 Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F 219-22-0175 90 Maryland Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or froms 23a or 28a-f show treumstic event, the Medical Exercises must be notified at Ruxton Maryland Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ä 21204 7907 Ruxway Rd. United States Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Yaar or Datas; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien. 11. Meritel Stetus Bleck, White, etc. 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2XX No Specify: Specify: white b 3 XWidowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) bookkeeper nut & candy co. 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fethar's Name (First, Middle, Last) h and Mental I Caroline Amersbach Harry Belsinger Pages 1 and 2 should I 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a : If item 27 is or other tre Timonium, MD 21093 11700 Fallswood Terrace Jeanne Mitcherling/niece Baltimore, 20b. Place of Disposition (Name of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 N Buriel 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) cematery, cremetory or other piece)

01–02–01

Dulaney Valley Mem Gardens 1/2/00 Timonium, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc 21. Signature of Funeral Service Licensee 6500 York Rd. Muchel Baltimore, MD 21212 23a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical week Examiner Examin Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician the burla Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2 No 0 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Invastigation Neturel 1 Tes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide after Dire b 24 hours a Funeral D etely filled 29a. Certifier Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner steted. edicai (Check only one) Within 2 Within 2 To the I 29b. Signature epo title of pertifier 29d. Date signed (Month, Dey, Year) 29c. License number December 30, 2000 uno ted cause of death (Item 23a) (Type, Print) 30. Nema end address of person who comp 1. Chales St. Balto mil 66 6701 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State JAN 3 2001 Registrar **DHMH 16 Rev 6/95 ORIGINAL**



State Registrar 31. Date filed (Month, Dey, Year) JAN 0 3 2001

JACK

29b. Signatura and fitla of certifia

11745 miD 32. Registrer's Signature

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

Mi

111 Penn Street, Baltimore, Maryland 21201 oaks

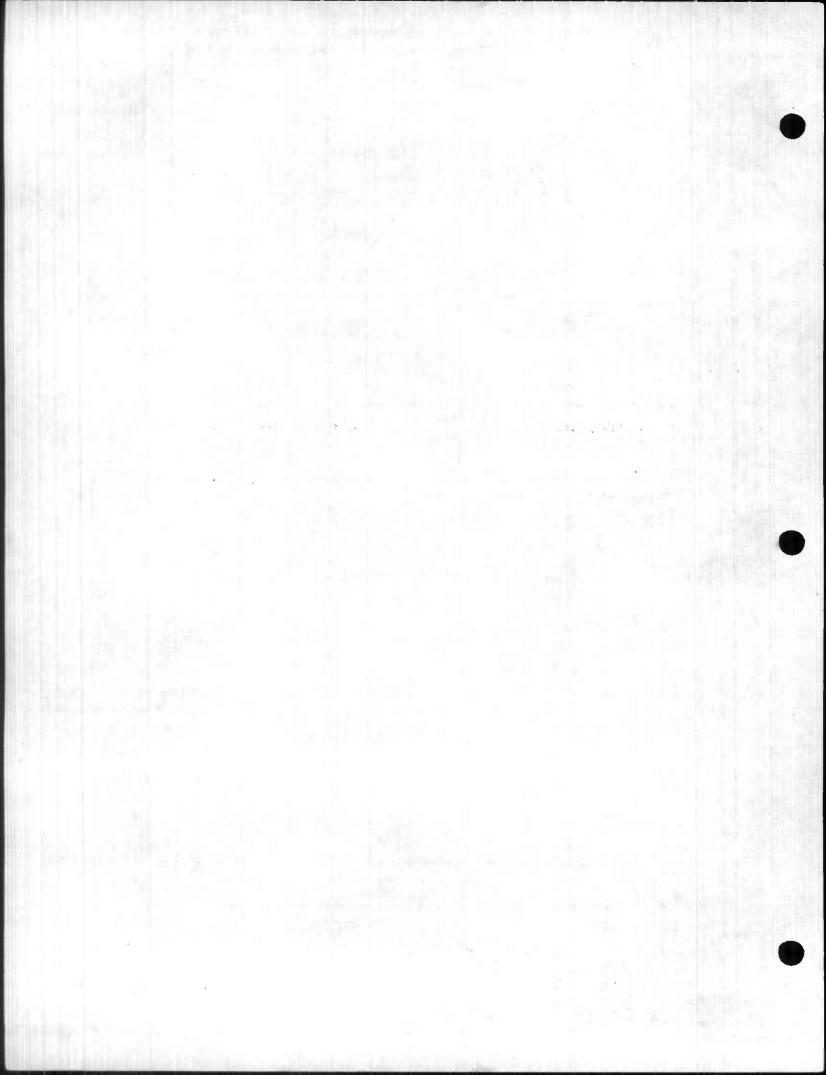
ORIGINAL

29c. License number

O.C.M.E.

29d. Data signed (Month, Dey, Year)

December 30, 2000



State of Maryland /

Department of I	Health and	Mental	Hygiene	N
0-416-4-4	Donall		0	\cup

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S	IEG	FR1	ED	
J	ONE	S		
J	ONE	S	-	

Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician**

1 M 2 F

2. Date of Death 3. Time of Death Month Dev Year 6:05P.M.

Reg. No.

SIEGFRIED RYAN - JONES DECEMBER 29,2000 /Medical 4e Fecility Name (ff not Institution, give street and number) 4b. City, Town, or Location of Death Examiner GAITHERSBURG
If Under 24 Hrs. 8. Dete 9619 MARATHON TERRACE 5. Social Security Number 7. Age (fn yrs. last birthday) If Under 1 Year 6 Sax

42

10c. City. Town or Location

4c. County of Death MONTGOMERY 8. Dete of Birth (Month, Day, Year) 05/06/1958 9. Birthplace (State or Foreign

GERMANY

Funeral Director

r items 23s or 3 sner must be n

'natural', or item dical Examiner

r than "natural the Medical

filled within

Hygiene.

. Pages 1 and 2 should be fill than of Health and Mental H tant. If Itam 27 is marked oth dury or other traumatic even

Department of Important: If it any Injury or o

physician and the bunal-transit

attending phy

signed by the a d be detached i

been si

is certificate has b I director, page 2 s

this funeral

To the Hospital or Attending Pt.
Thin A hours after death.
To the Funeral Director: After the completely filled in by the funeral

the death certificate be axecuted

Records, P.O. Box 68760.

Division of Vital

Physician:

Baltimore, Maryland 21215-0036

Directo

Funeral

þ

Completed

88

10a State 10b County CT. FAIRFIELD

REDDING 10f. Zip Code 10g. Citizen of What Country?

10d. Inside City Limits 1 □ Yes 3 No

10e. Street and Number 16 HOPEWELL WOODS RD.

226-02-4667

Usual Residence of Decedent

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 20 No If Yes, Give

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1□ Yes 2 No Specify:

Hours

14. Race - American Indian, Black, White, etc. Specify: WHITE

1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed) Collega (1-4or 5+) 4YRS

16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) INSURANCE EXECUTIVE

22. Nama and Address of Facility

06896

Days

Months

H. JACKSON STEARNS

Elementary/Secondary (0-12) 17. Fether's Name (First, Middle, Last)

JAMES

JONES

18. Mother's Name (First, Middle, Maiden Sumame)

UTE ECKARDT

19a. Informant's Name/Raletionship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)

JANET RYAN-JONES (WIFE)

16 HOPEWELL WOODS RD. REDDING, CT. 06896. 20b. Placa of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, State

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 圖 Removal trom State 4 ☐ Donation 5 ☐ Other (Specify)

UMPAWAUG CEMETERY

03/01/2001 REDDING, CT.

USA

16b. Kind of Business/Industry

21. Signeture of Funeral Service Licensee Willsok

HENRY W. JENKINS & SONS (4905 YORK RD. BALTO., MD. SONS CO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Physician /Medical Immediate Cause (Final diseasa or condition rasulting in daath) Examiner

Examine

Physician/Medical

by

Completed

Be

10

Certification:

edicai

Hemopericardium Due to (or as a consequenca of):

Anewysm dissecting Due to (bras a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Wera autopsy tindings evailable prior to 24a. Was an autopsy performed?

25. Was casa referred to medical

1 Nes 2 No 26. Place of Death (Check only ona)

completion of cause of death? 1 Yas 2□ No

Approximata Interval Between Onset and Death

1 XYes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residenca 6 MOther (Specify) SCENE 28d. Dascribe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

5 Pending Invastigation 6 Could not be detarmined

28c. Injury at Work? 1 Yes 2 No 28a. Place of Injury - At homa, farm, street, tactory, offica building, atc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated.

29b. Signature end title of cartities

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

DECEMBER 29,2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

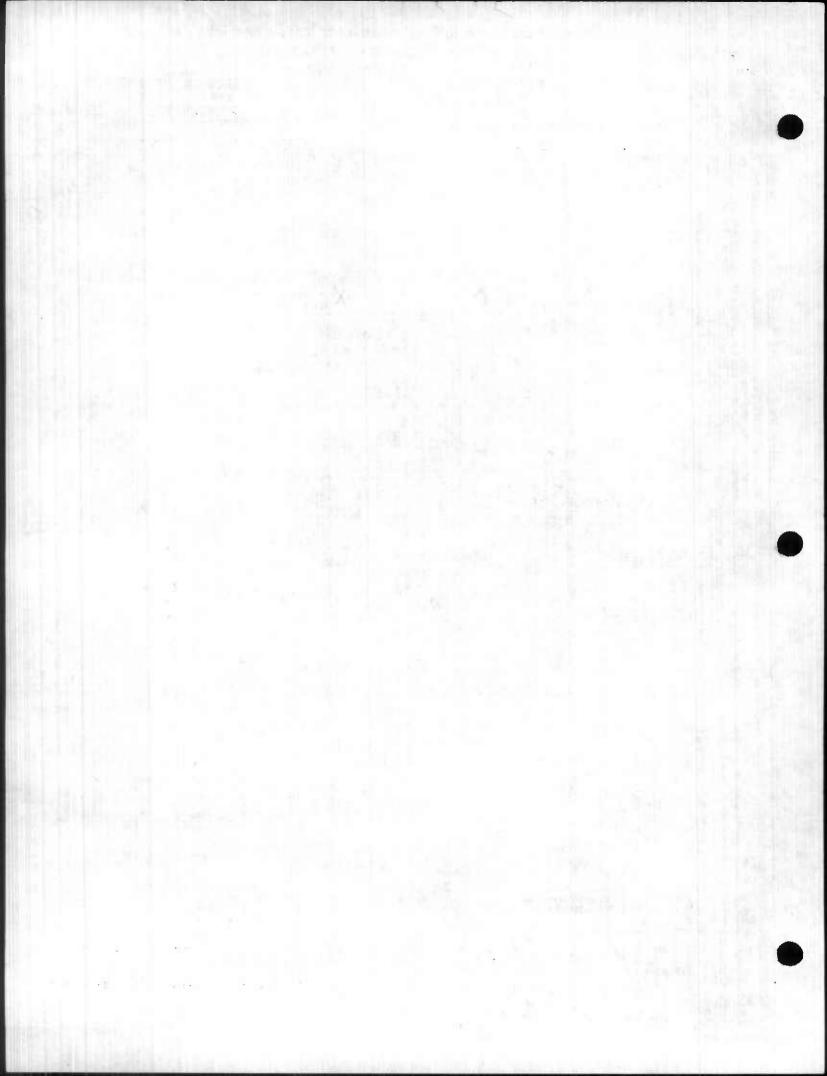
Chutem nnis

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)
JAN 0 3 2001

32. Registrar'a Slopature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42764 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** erwin 3:28 PM December 2000 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Baltimore laryland Baltmore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** Days Months Hours 1**X** M 2□ F 76 Director 07/31/1924 Maryland 216-18-3708 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Ves 2 □ No Baltimore Maryland Directo must be notifie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21217 U.S.A. 1412 Division Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 117 Yes 2 □ No If Yes, Give 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black, White, etc. the Medical Examiner 1 Never Merried 2 ☐ Married 8 1 ☐ Yes 2 ☑ No Specify: 1946 Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. Truck Driver Lumber 9 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be fishment of Health and Mantal Hism; if flem 27 is marked oth 89 Mildred Vivian Brooks William McKinley Kirkland 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1412 Division St., Baltimore, Maryland 21217 Mildred Baynor / Sister 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify) Garrison Forest VA Ceme. 01/04/010wings Mills, Maryland 21. Signeture of Fundral Sando Licer 22. Name end Address of Fecility Derrick C. Jones Funeral Home 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Physician/Medicai Due to (or es a consequence of): use as t 23h. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed certificate has av lery 1 X Yes Coronary 2 No 1 Yes 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this 28a. Dete of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Injury To the Hospital or Attending Pt whin 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28c. Injury at Work? Certification: After 5 Pending Investigation 1 Neturel 2 Accident 1□Yes 2□No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

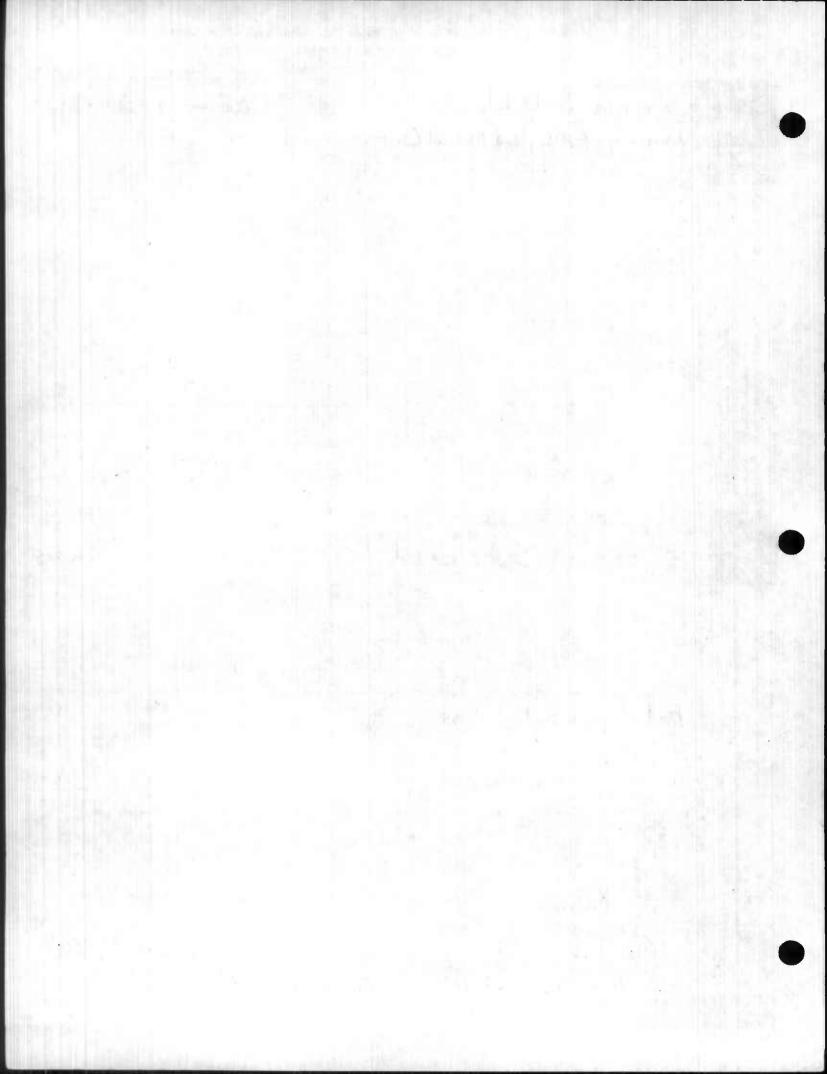
Waterfall Cou 32. Régistrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Dete filed (Month, Dey, Year)

Owings Mills, MD 21117

DHMH 16 Rev 6/95



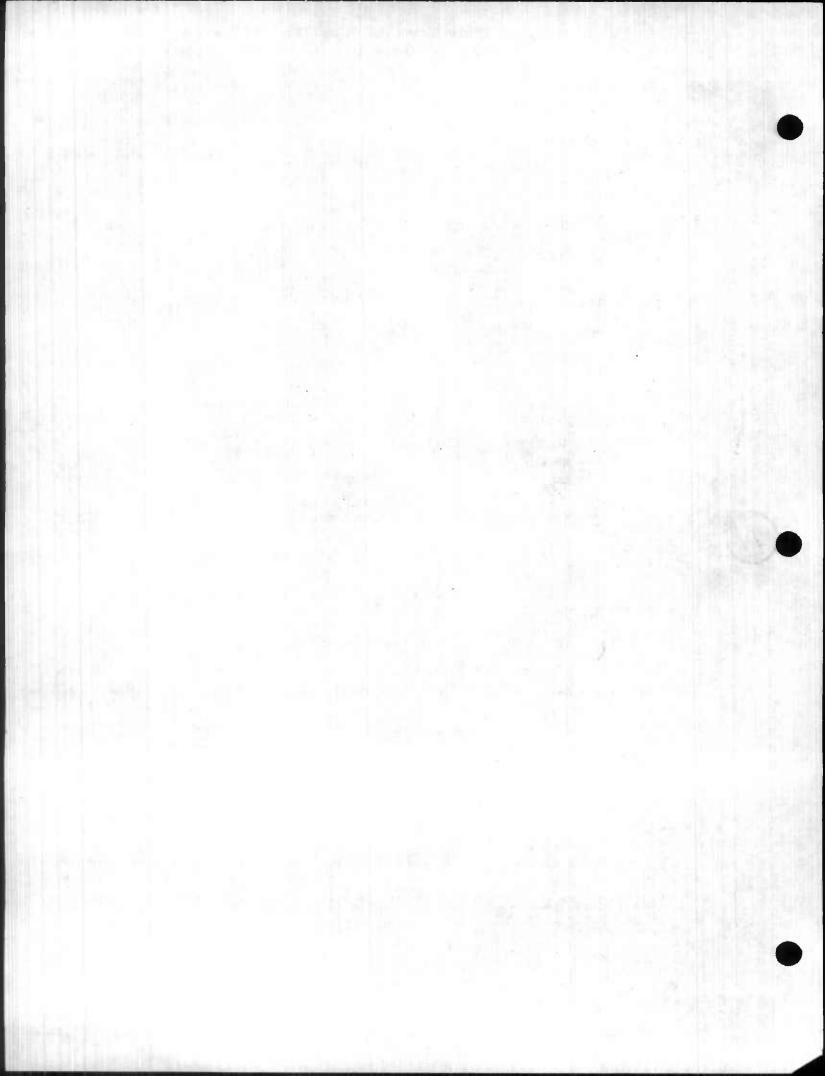
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Year **Physician** RENIE F. KREMER DEC 23 2000 8AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3801 SCHNAPER DRIVE # 112 RANDALLSTOWN BALTIMORE If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) NOV 9 1926 9. Birthplace (State or Foreign Country)
BALTO. MD. 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Hours Min. Days 1□M 2√2F Yrs. 219-10-0055 74 Director Usual Residence of Decedent 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No herns 23s or 28s-f si her must be notified Director BALTIMORE RANDALLSTOWN 10e. Street and Number 10a. Citizen of Whet Country? 10f. Zip Code 3801 SCHNAPER DRIVE # 112 21133 USA Funeral 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give than "natural", or item the Medical Examiner. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify:WHITE by Yeer or Dates: 3€ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry filed within Elementery/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 88 Pages 1 and 2 should be nent of Health and Mental MORRIS SILVERMAN ANNA KATZ 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Department of Health as important: if item 27 is any injury or other tras SHARON STERN/DAUGHTER 629 LEAFYDALE TERRACE BALTIMORE.MD. 21208 20a. Method of Disposition 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, State BETH TFILOH CONGREGATION 12/24/00 WOODLAWN, MD. 1 N Buriel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 22. Neme and Address of Fecility 21. Signature of Funayal Service Lice SOL LEVINSON & BROS, INC, 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death F-hysician | A cute myocordial tom Poxlian /Medical Immediate Ceuse (Final disease or condition resulting in deeth) tmexit **E**_aminer Examine the death certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Latt Due to (or es e consequença of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as e consequence of): attending pt signed by the a d be detached f 23b. Dfd tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2 40 3 Probably 4 Unknown by The law requires 24b. Were eutopsy findings available prior to completion of cause of death? Rinal failure 24a. Wes en eutopsy performed? Completed Is certificate has I director, page 2 : 1 Yes 2 W6 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 27. Menner of Death 1 Dentural 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation death. 1 Yes 2 No 2 Accident by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) Direc 4 | Homicide 24 hours after Funeral Directory filled in b Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner es stated. edical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 2 THE PERSON 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0 30. Name and address of persor who completed cause of deeth (Item 23a) (Type, Print) 21 (1095) Oach D) · Ouing milts, mil 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Carol S. Kays December 30 2000 11:26pm 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Month, Day, Year, 11/27/1941 5. Social Security Number 9. Birthplace (State or Foreign Country) Months Deys 1 M 2 N F Hours Min. 59 Yrs. 219-44-7704 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 107 Aylesbury Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker City of Baltimore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Alta B. McDonald Charles J. Stinchcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Aylesbury Road; Timonium, MD 21093 Bradley Kays / husband 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donafion 5 Other (Specify) 1/4/01 Towson, MD Hilltop Service Corp. 21. Signature of Funaral Service Licenses 22. Name and Address of Facility 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Towson, MD 21204 Ruck Towson Funeral Home, Inc. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Malmuts Fin 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient DEBOutpatienf 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician/Medical Examiner The law requires that the death certificate be executed Box 68760. ed by the attending physician detached for use as the buria Division of VItal Records, P.O. signed by the After this certificate has or Attending Physician: funeral ours after death. eral Diractor: Aff filled in by the fur

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

by

Completed

item 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Madical Examinar must be notified at

e filed within 72 hours after al Hygiene. other than "natural", or fle

Pages 1 and 2 should be in nent of Health and Mental int: If Item 27 is marked or

pemit. Pages Depertment of I Important: If its any injury or o

Physician

/Medical

Examiner

Maryland 21215-0020

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. þ Completed 25. Was case referred to medical examiner? Be 1□ Yes No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide

within 24 hours a To the Funeral C completely filled

edical

29a Certifier

ACC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

(1700, Print) N. Charles St Baltimne MD 21204

29b. Signature and title of certifier Clowse 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Mathy
C. Clorest, Mp. 6575

29c. License number, M.D. 112 # 1054937

31. Date filed (Month, Day, Year)

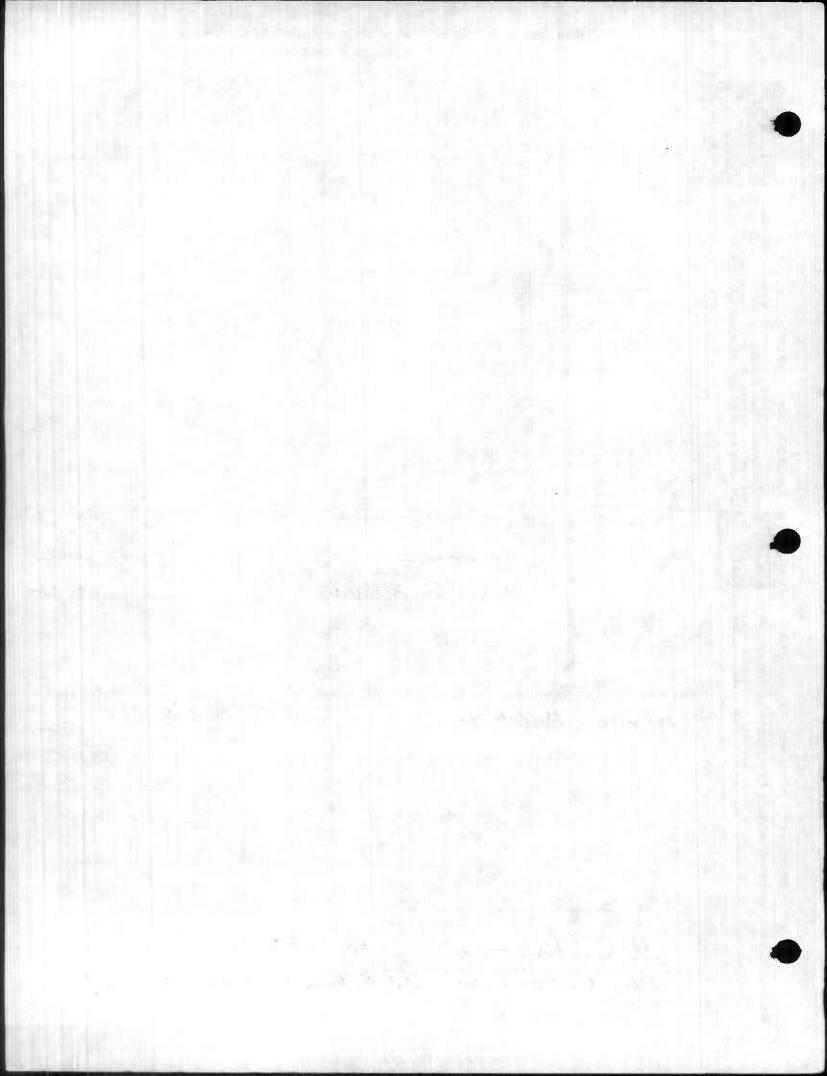
32. Registrar's Signature

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State Registrar

DHMH 16 Rev 6/95

Hospital

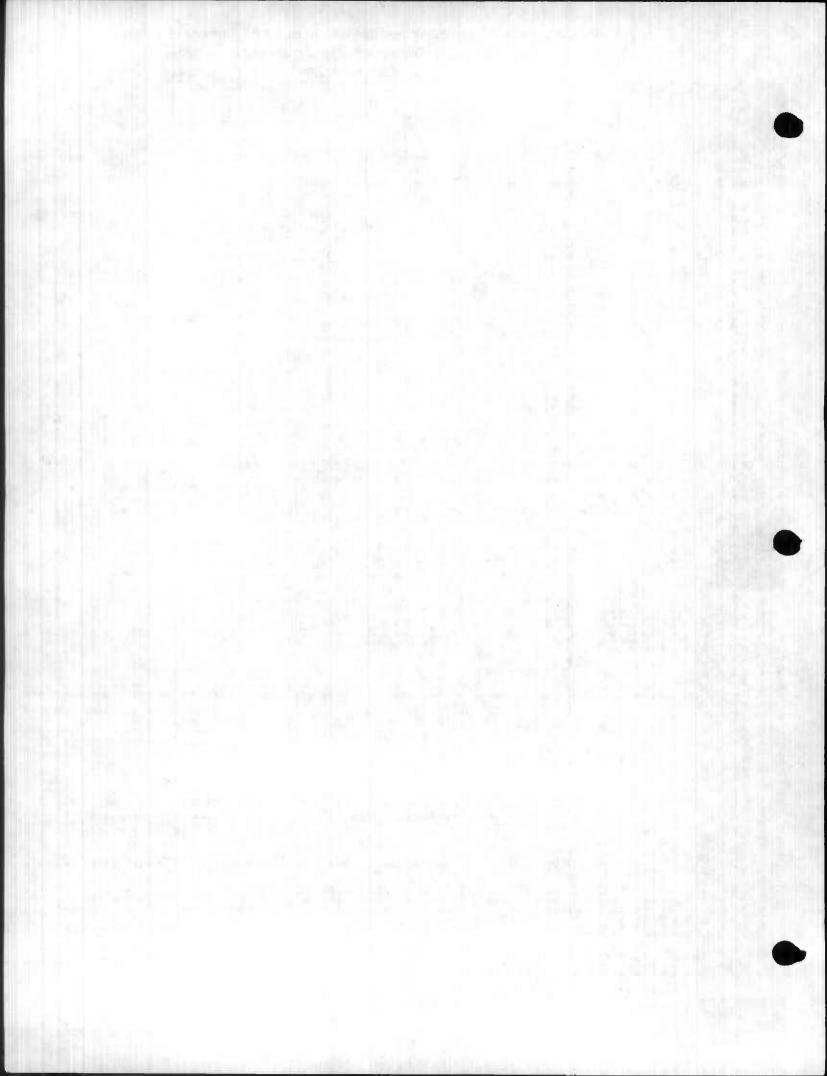


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rea No. 0 4 2 0 4 7

Physician			Certificat	0 0. 0 00	116	g. No.		
Physician	1. Decedent's Neme (First, Middle, Last)			2. Dete of Deeth		3. Time of Death	
49.4 42 4	Emma J	Kidwell			Month 7		Year 1201	
/Medical	4e Facility Neme (If not institution, give			4b. City, Town, or	Location of Deeth	4c. County of		ĺ
Examiner				152140		/	120	
	Johns Hoplems		last hirthday) If Under	dire.	_	<u> </u>	7-4	
uneral	5. Social Security Number 6. Se	7. Age (In yrs. I	Months	Deys Hours Min	(Month, Dey,		9. Birthblace (State or Foreign Country)	
rector	212 377753	66	Yrs.		8-16	-35 /	Pennsylvania	
	Uauel Residence of Decedent	Lie ei	-				Lieux is on the	
e notified at Director	10a. Stete 10b. County		, Town or Location			2	10d. Inside City Limits	
at be notified at al Director	MP BALT	IMORE B.	ALTIM	ORE (DI	INDAZK	()	1 ☐ Yes 2 ☐ No	
Director	10e. Street and Number	70,00	10f. Zip			g. Citizen of W	hat Country?	
ā	711 /	11.		11222		U.S.		
Funeral	SOOL GOUTT	WAY	0	1200				
- P	11. Merital Status	12. Wes Decedent Ever in U.	S. 13. Wes Deced	dent of Hispenic Origin? (S cify Cuben, Mexican, Pue	Specify Yes or No- to Rican, etc.)		- American Indian, c, White, etc.	ı
	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		2 DINO Specify:		Consider	1.151	ı
by	3 Widowed 4 Divorced	Yeer or Dates:	10 163	ZETTO Specify.		Specify:	White	
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Be Completed	(Specify only highest grad		(Give kind of wo	rk done during most of wo se ratired)	rking			
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2	MAKIIN SI	Kenich		HNN	A STRE	1711		
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8	21. Signeture of Funeral Service Licens	000	22. Neme en	d Address of Facility Velly Fine Les of diving such as cardia	14.10	SNEALK	PA.	ı
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an 💮							Onset and Doddin	Į
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er	rasulting in death)	Due to (or	r ea e consequence of):					l
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	Convention No. No. of the last	b. — Due to for	r as a consequence of					١
xan	Sequentially list conditions, if any, leading to immediate	bDue to (or	r es e consequence of):					
al Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	с						
dical Exan	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	r es e consequence of):					
Medical Examiner	that initiated events	с						
3	that initiated events	с						
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3	that initiated events	cDue to (or	es e consequence of):	euse given in Pert f.			stribute to the cause of death?	
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3	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	es e consequence of):	euse given in Pert f.	1 ☐ Ye	es 2 No	3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Dav Vaar **Physician** 6549am Gene Donald Klausing 2000 December 27 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner Belair Harford Upper Chesapeake Medical Center 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) | ff Under 1 Yaar | ff Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Sacurity Number Birthplace (Stata or Foreign Country) **Funeral** 1X M 2□ F 77 215-12-9333 Director Usual Residence of Decedant 10d. Insida City Limits 10c. City, Town or Location 10a Stata 10h County 1 ☐ Yas 2X No Kingsville Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? "natural", or items 23s or address Examiner must be 21087 USA 7911 Redstone Road Funerai 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ZNo If Yes, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White by 3 ☐ Widowad 4 ☐ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) filed within Elementery/Secondary (0-12) Collega (1-4or 5+) Hyglena. President Savings Bank 18. Mothar's Nama (First, Middle, Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) of Health end Mental H item 27 is marked oth r other traumatic even Be Pages 1 and 2 should be 1 nent of Health end Mental I Mary Hruby John M. Klausing 19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Gertrude G.Klausing - wife 7911 Redstone Road, Kingsville, MD 21087 20a. Mathod of Disposition

1 Burial 2 Cramation 3 Ramoval from Stata 20b. Place of Disposition (Nama of cematery, crametory or other place) Data 20c. Location - City or Town, State Important: If it any injury or Depertment Gardens of Faith Cem. 12/30/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Mitchell-Wiedefeld Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensee 6500 York Rd. Baltimore, MD 21212 23a Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Physician Immediata Causa (Finat disaasa or condition resulting in death) /Medical ancrea Examiner Physician/Medical Examiner Luceks the death certificate be axecuted ettending physician and for use as the burlal-trans Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or injury that initiated avants rasulting in death) Last weeks P.O. Box 68760, (anal) a source paiman whection 234 Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown þ Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 ☐ No 1 Yas ally Division of Vital 25. Was casa rafarrad to medical axaminar? Be 6. Placa of Death (Check only one) Other: 4 Nursing Homa Hospital: 1 Impatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 10 5 ☐ Rasidence 6 ☐ Othar (Specify) this 27. Mennar of Daet 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Netural 2 Accidant 5 Panding invastigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To tha best of my knowledga, death occurred at the time, date end place, end due to the cause(s) and manner es steled.

Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and manner statad. 29a. Certifier edicai (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar Jun, M.D 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Harford Road Ste. 105 Fallston MD 21047 SUN S.C. 1716 M.D. 31. Data filed (Month, Day, Year) State 32. Registrar's Signatura

DHMH 16 Rev 6/95

Registrar

JAN

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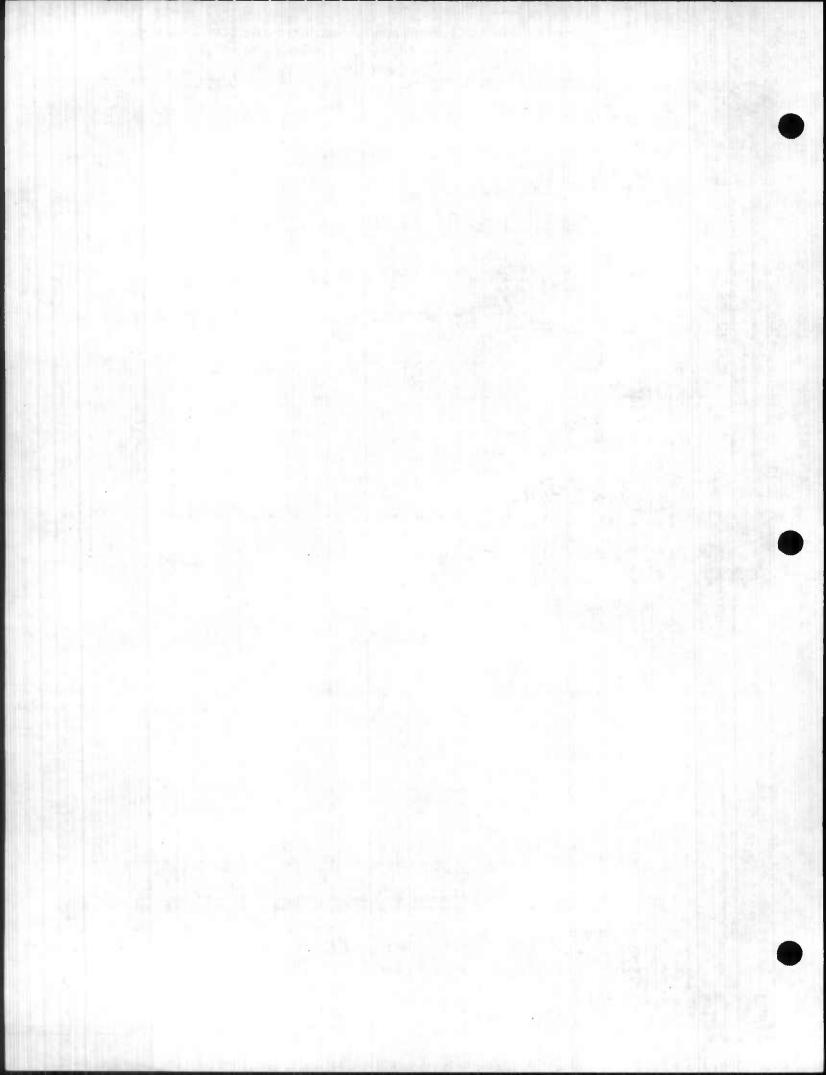
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State of Maryland / Department of Health and Mental Hygiene 4 2049

			Ce	rtificate of	Death		Reg. No.	460	4)
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Physiciar /Medica		E KOEHLER				Mont Dec	26 2	000 1	0:00 a.m.
Examine	An English Name // not institution sky	e street and number)			4b. City, Tow	vn, or Location of	Death 4c. Count	y of Deeth	
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Funeral Director	210 07 0714	7. Age (In yr	s. last birthday, Yrs.	If Under 1 Year Months Deys		Min. 8. Date (Mont	of Birth h, Day, Year) 15,1917	9. Birthplace Country) Maryla	a (Stete or Foreign and
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the Marylar 28a-f show noof se	Maryland Baltimo	ore Ba	ltimore						1 ☐ Yes 2 ☒ No
£ 6 2				10f. Zip Code 2121			U.S.A	•	
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Physician	shock, or heart feilure. List only							Or	tervet Between nset end Death
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8760, sate be assecuted hysician end the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or as e conse	quence of):					
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Geath death	Pert II. Other significant conditions or	ontributing to deeth but not re	esulting in the	underlying cause g	iven in Pert I.	23b	. Did tobacco use c	ontributa to th	e causa of death?
P.O.							1□ Yes 2 No	3 Probab	oly 4 Unknown
cords			48			24e.	Wes en eutopsy performed?	evaila	eutopsy tindings able prior to eletion of cause ath?
The law ate has pege 2	5						1□ Yes 2 No	1 DY	res 2□ No
Vital Indicate rector, peg	25. Wes case referred to medical				26. Plece	of Deeth (Check	only one)		
Of Vita Physician: this certific		Hospitel: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA	ther: 4 Nu	rsing Home 5	Residence 6 XO	ther (Specify)	tospice
C g sel		28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury		uryet ork?]Yes 2 ☐ h		cribe how injury occu	ırred	
Division of Attance after death Director:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At building, etc. (Spe	home, ferm, si	treet, factory, office			tion (Street end Num or Town, Stete)	ber or Rurel R	loute Number,
Division (To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: Affert completely filled in by the funeral	29a. Cartifier (Check only one) Certifying Physics (Check only one)	yelcian: To the best of my k hiner: On the basis of exami end menner steted.	nowledge, dee netion end/or ir	th occurred et the to executive to the total t	ime, date end opinion, deat	d place, and due t th occurred at the	to the cause(s) and n time, date end place	nenner as state , end due to th	ed. e cause(s)
o the	29b. Signeture and alte of partifier	0 10			se number		29d. Dete sign		
F \$ F 0) A Hath	my Kil.	m	1 1	2120	5	Donou	uboro	26,2000
10	30. Name end address of person who	completed cause of death for	em 23a) (Type	Print)	alles	G	Balts	Md	26,2000
State	14/14 9 200	32. Registrer's Sig	neture	14.00	10	٠ ١٠,	rucio.	7713	2120/2
Registra	JAN 3 200	A	/	Lyon	13				

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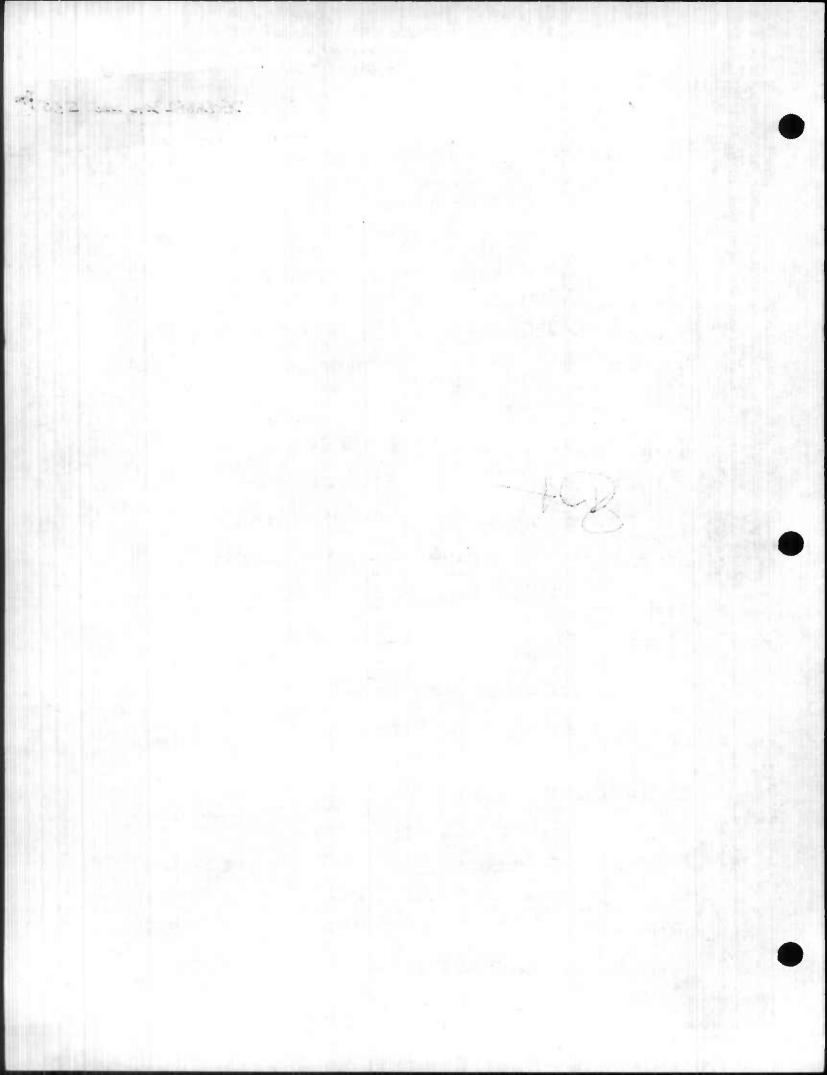
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

42050

Physician /Medical	Lemonia Kouroupis			2. Dete of Death Month Dey DECSMB6230	
Examiner	to Casilly blome (Mant Institution also stone and number)		4b. City, Town, or Loc Baltimore		ny di Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In 217-32-8993	yrs. lest birthday) H Under 1 Ye Months Day	er If Under 24 Hrs.	8. Date of Birth (Month, Dey, Year) 07/22/1906	9. Birthplece (State or Foreign Country) Greece
Meryland a-f ahow		c. City, Town or Location Baltimore			10d. Inside City Limits 1 XYes 2 ☐ No
vith the Mer t or 28s-1 all be notified Director	10e. Street end Number	10f. Zip Cod			Whet Country?
a 23a		in II S 12 Man Docadent of	21224		JSA
11215-0036 within 72 hours effer death with the Meryland ene. Than "natural", or ferms 23s or 28s-4 show the Medical Essentine must be notified a sympleted by Funeral Director	3 Widowed 4 □ Divorced If Yes, Give Yeer or Detes:	If Yes, specify C	of Hispanic Origin? (Specuban, Mexican, Puerto F No Specify:	Spec	ack, White, etc.
21215-0036 ed within 72 hours ef vylene; than "netural; or t, the tendes Eram Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		cupation ne during most of workin ired)	9	Business/Industry
O DE		Homemaker	18. Mother's Name	(First, Middle, Meiden Sume	n Home
should be and Mentel marked o umatic ave	John Kouroupis		-	e Belegri	
Par sum	19a. Informent's Neme/Reletionship (Type, Print) John Kouroupis Son			Route Number, City or Town Millersville	
	20e. Method of Disposition	Ob. Plece of Disposition (Name of cametery, cremetory or other)			- City or Town, State
	1 ■ Buriel 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify)	Greek Orthodox C		./04/01 Baltin	more, MD
Baltimo permit. Page Department Important: If any injury of pngs.	21. Signature of Funeral Service Licensee			news Funeral ! ED BAltimore,	
Physician	23a. Pert1. Enter the disease, or complications that caused the shock, or lixant failure. List only one cause on each line.				Approximete Interval Between Onset end Deeth
/Medical Examiner	Due	re broundulur to (or es e consequence of):	Acud	ert	
executed in end ist-trensit	Sequentially list conditions, if any, leading to immediate	to (or es e consequence of):			
Box 68760, ath certificate be executed ittending physician end or use as the burial-trensit an/Medical Examir		to (or es e consequence of):		3	
OX 6	d				1
the dearly the a sched f		t resulting in the underlying cause	given in Pert I.	23b. Dfd tobacco use of	ontribute to the cause of death?
ords requires sen sign hould be				24a. Wes en eutopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of deeth?
The law ate hes b page 2 s				1□ Yes 2⊅No	1 ☐ Yes 2 ☐ No
/its	25. Was case referred to medical examiner?		26. Place of Deeth	(Check only one)	1
T die T	1 Inpatient	28b. Time of lnjury 28c. li		ne 5 Residence 6 0 8d. Describe how injury occ	Ther (Specify) NOSpill
D Page P	3 Suicide 6 Could not be determined 28e. Plece of Injury - building, etc. (S	At home, ferm, street, factory, offi pecify)	Ce 2	8f. Location (Street end Nur City or Town, State)	nber or Rural Route Number,
The Hospital mir 24 hours the Funeral registery filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 1 Medical Examiner: On the basis of examiner end menner steted.				
No. of the last of	29b. Signeture end title of certifier A A A		PY0854	29d. Dete sign	ned (Month, Day, Year)
27	30. Name and eddress of person who completed cause of deeth	111	St Park	PI Bultimer	21202
State Registrar	31. Dete filed (Month, Day, Year) JAN 03 2007 32. Registrer's 3	Signature & Spi	nks)		
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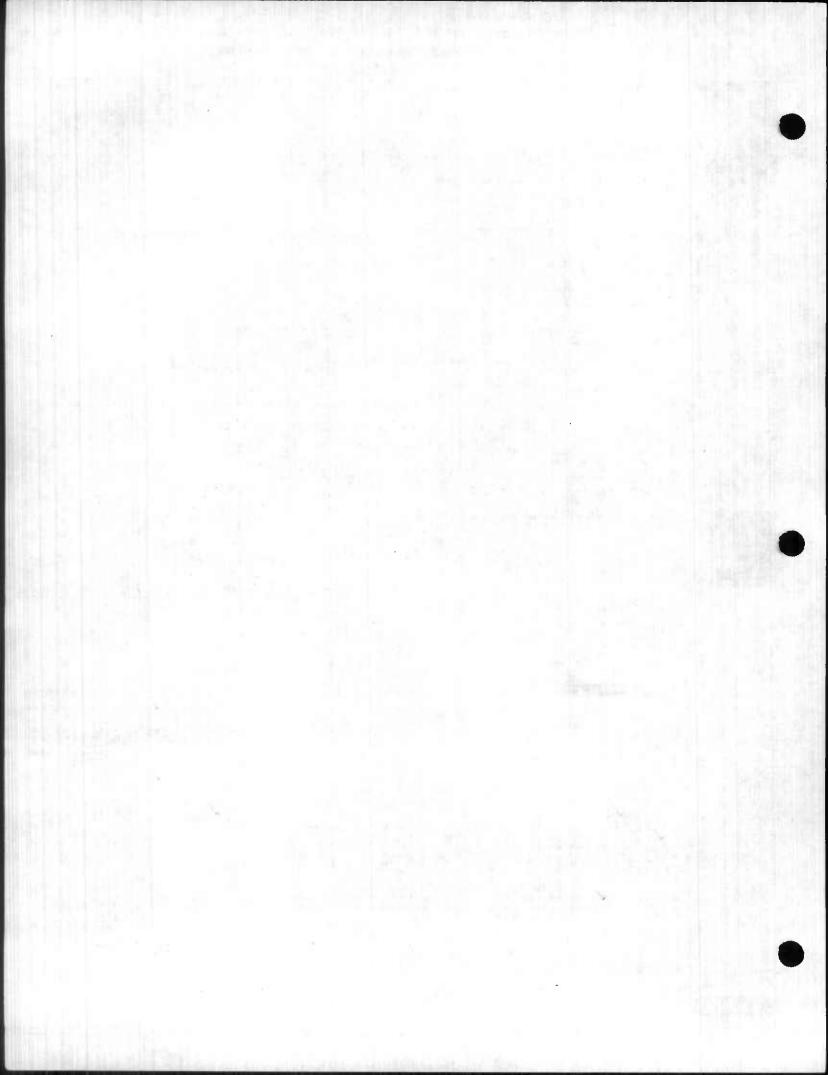
State of Maryland / Department of Health and Mental Hygiene 1, 205

			Cei	rtificate	e of	Death		Reg. No.	46	001	
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006-84-1932	6. Sex 1 M 2 □ F	1. Aga (in yrs.	Yrs.	Months	Days		n. JUL 11	1986	Coun	try)	rron
	,	10c. City	y, Town or Lo	ocation	-				11	0d. Inside C	ity Lin
aryland Anne	Arundel	Anna	apolis							1 🗆 Yes	20
0e. Street and Number				10f. Zip	Coda			10g. Citizen of	What Coun	try?	
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	Last)		2.7.2.2		V	18. Mother's N	eme (First, Middle				
Daryl A. Leger	r					Eliza	beth Hol	land			
19a. Informant's Name/Ralations	ship (Type, Print)		19b. Mailir	ng Addrass	(Stree	and Number or	Rural Routa Numb	er, City or Town	, Steta, Zip	Code)	1,5
Daryl A. Leger	/Father					e Anna	polis, M	21403	3		
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mat miliated evants	C	Due to /o	r as e consec	nuence of):					-		
asulting in death) Last	100	Dua to (0	. as a conseq	ruoniue Uij.							
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Part II. Other significant condition	one contributing to d	eath but not ras	ulting in tha u	inderlying ca	ause gi	van in Part I.	23b. Did	tobacco use co	ontribute to	the cause	of de
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							24a. Wa	s an eutopsy ormed?	av.	ailabla prior mplation of	to
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25. Was cesa rafarred to medica axaminar? 1 Yes 2 No	Hospital: 1			4 10	8c. Inju	iry at	28d. Dascribe	how injury occu	rred		
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1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Michael Rober le Facility Nama (III not Institution 113 Lee Drive 5. Social Security Number 006-84-1932 Usual Residance of Dacedant 10a. Stete 10b. County lary Land Anne 113 Lee Drive 11. Marital Stetus 11 Nevar Married 2 Mart 12 Martial Stetus 12 Nevar Married 2 Mart 13 Widowed 4 Divorced (Specify only higher Elementery/Secondery (0-12) N/A 17. Fathar's Nama (First, Middla, Daryl A. Leger) 19a. Informant's Name/Ralations Daryl A. Leger 20e. Mathod of Disposition 1 Burial 2 M Cramation 4 Donation 5 Othar (Secondary County County) 21. Signature of Euroeral Sarvice Thomas Green 23a. Pert1. Enter tha disaesa, on shock, or haart failure. List Immediate Ceuse (Finel disease or condition rasulting in death) Sequentially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last	113 Lee Drive 5. Social Security Number 006-84-1932 Usual Residance of Dacedant 10a. Stete 10b. 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Was Decedent's Education (Specify only highest grade complated) Elementery/Spcondery (0-12) N/A 17. Fathar's Nama (First, Middla, Lest) Daryl A. Leger 19a. Informant's Name/Relationship (Type, Print) Daryl A. Leger/Father 20c. Method of Disposition 1 Burial 2 Nothar (Specify) 21. Signature of Eugeral Sarvice Licenses Thomas Gregor 22. Nama en Cremator Sequentially list conditions, if any, laading to immadiate couse. Entar Underlying Cause (Disses or Injury Due to (or as a consequence of): Due to (or as a consequence of):	Michael Robert Leger The Facility Nama (If not institution, giva street and number) 113 Lee Drive 5. Social Security Number 006-84-1932 Usual Residance of Dacedant 1006. Stete 1006. County Anne Arundel Annapolis 1006. Street and Number 113 Lee Drive 114 Yrs. 115 Decedent Ever in U.S. 115 Nevar Married 2 Married 115 Nevar Married 2 Married 116 Specify only highest grade complated) 117 Fathar's Nama (First, Middla, Last) Daryl A. Leger 119a. 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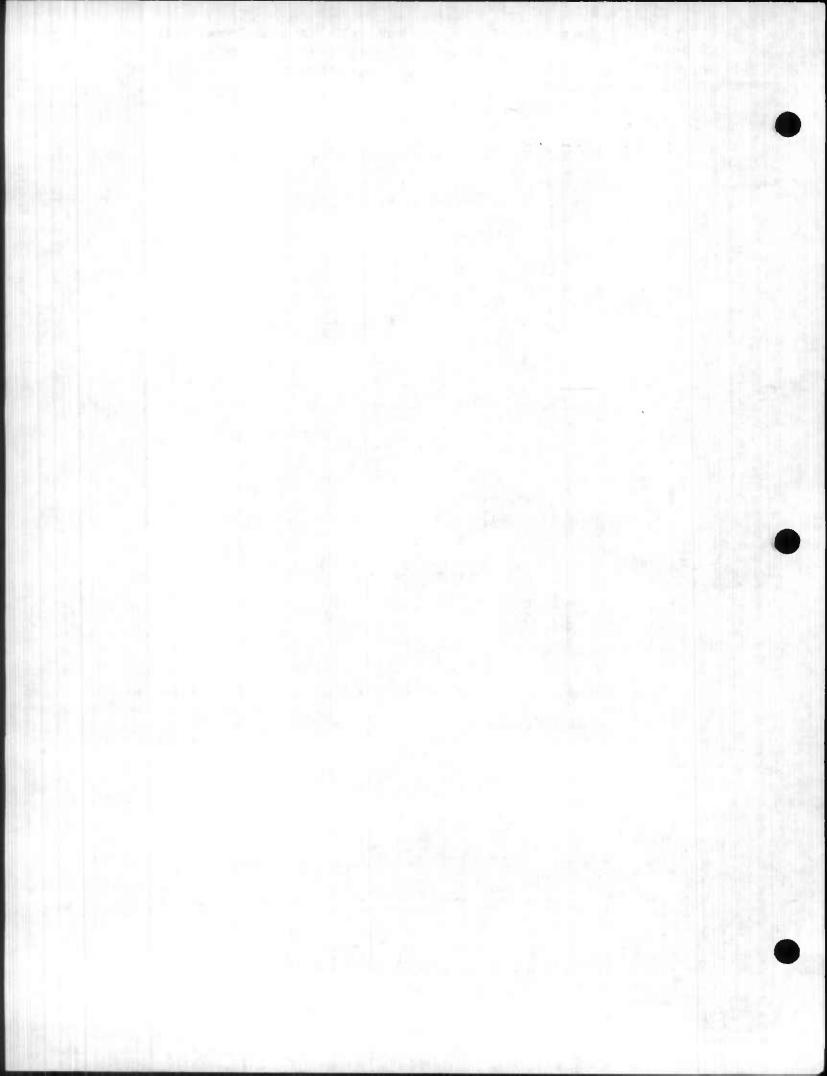
Registrar

JAN 3 2001



Amended	Ite	em#17 perFHG791 1/3/20		Marylan		artment o			and M	lental Hyg	jiene ()	42	052	
	,	1. Decedent's Neme (First, Middle, La	ast)							2. Date of Dea Month		Year	3. Time o	of Death
Physic /Medi		Margaret Agnes	Lorber							Dec.	30 200		4:	45 AN
Exami	ner	4a Facility Name (If not Institution, git					4			cation of Deeth	4c. County			
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and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						-	10d. Inside (City Limits
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	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Date	, ,		1□ Yes 2X	No	Specify:			Specify	Wh	ite	
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arylan should be nd Mentel merked o	To	Henry A. Dertz								P. Kree				
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Baltimore, pemir. Pages 1 at Department of Nee Important: If Hem any Injury or otheone.		21. Signature of Funeral Servica Lice	hspe /		2	2. Name and A	Addres	s of Facilit	у					11
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Physician /Medical		Immediate Cause (Final	H	In	11.	lin							4 20	2
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= F 5 6		25. Was case referred to medical						00 Pl	-4 D44	1 Y	10	1	☐ Yes 2	XUNO
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	Certification:	4 Homicide determined	286. Flece of	thjury - At he , etc. (Specif	ome, farm, st	reet, factory, o	offica			28f. Location (S City or Tow		er or Hur	a <i>i Houte i</i> vu	m <i>ber</i> ,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Pi	nysician: To the be	est of my kno	wledge, deet	h occurred et l	the tim	ne, dete en	d plece,	end due to the o	euse(s) end me	onner as	stated	(a)
To the Ho within 24 To the Fu complete	Medical	one)	miner: On the besi and manne		non end/or in				in occurr					(2)
To Vill	-	29b. Signature and title of cartified	X 12	ua	nere	29c. L	D	3061	51		29d. Date signe	o (Month	ord g	2001
5	1	30. Name and address of person who	completed cause	of death (Item	23a) (Tuno	Print)		- 01			Tanua	70		MAD
	1	Sireesh Tripura					n E	3ldq.	, 56	01 Lock	Raven	Blv	d., E	MD Balto.,
Sta	ate	31. Dete filed (Month, Day, Year)"		istrar's Signa		6 1	OBR	Ks						

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State of Maryland / Department of Health and Mental Hygiene 0 1, 2 0 5 3

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			Cartificate of Dooth	

			Certifica	te of Death	R	eg. No.	2000	
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Funeral Director	5. Social Security Number 6. Se 150 10 4231 Usuel Residence of Decedent	7. Age (In yrs. In ₹M 2□ F 83	Ast birthday) If Under Months Yrs.	r 1 Yeer If Under 24 Hrs Deys Hours Min			rthplace (State or Fore country) ennsylvania	
ě m	10a. Stete 10b. County	10c. City	y, Town or Location				10d. Inside City Lim	
to to	Maryland N/A		Baltimore				1 ∑ Yes 2 □	
r tiems 23a or 28a-f show siner must be morthed at Funeral Director	10e. Street end Number 3902 Pennington	Avenue	10f. Z	21226	1	10g. Citizen of What Country? U.S.		
il, or items	11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1☑ Yes 2☐ No If Yes, Give Year or Dates:	S. 13. Was Dece If Yes, sp	edent of Hispanic Origin? (Secify Cuben, Mexican, Puel 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Arr Bleck, Wh Specify:		
"natural", adre Em	15. Decedent's Edu (Specify only highest grad	ication	16e. Decedent's Us	uel Occupetion	orkina	16b. Kind of Busines	s/Industry	
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2 2 2	20a. Method of Disposition 1 Burial 2 Coremetion 3 F 4 Donetion 5 Other (Specify)	Removel from State	emetery, cremetory or	other plece)	1/02/01	20c. Location - City o	, Maryland	
Department Important: I any Injury c	21. Signature of Funerel Service Licens	Dogs	1	and Address of Fecility Ritchie Highw		uneral Hom		
ysician	23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only o	ications that caused the deeth ne ceuse on each line.					Approximete Intervel Between Onset end Death	
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g physician and as the bunal-transit	Sequentially list conditions, if env. leading to immediate		r es e consequence of		ECTIO	N	DAT	
buria buria	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	с						
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by the ached	Part II. Other atgnificant conditions con	ntributing to death but not resu					te to the cause of de Probably 4 Unk	
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certificate rector, pag	25. Wes case referred to medical			00 8118-	1 \ Y		1 ☐ Yes 2 ☐ No	
	examiner?	Hospitel: 1 Impatient 2 1	ER/Outpetient 3 0	Other:	eth (Check only on		anciba)	
ther this	27. Menner of Death 1 Autural 5 Pending	28e. Date of Injury (Month, Dey Year)	28b. Time of tnjury	28c. Injury at Work?	1	ence 6 Other (Sp ow injury occurred	овсту)	
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At ho building, etc. (Specify		1 Yes 2 No	28f. Location (Si City or Town	reet end Number or n, Stele)	Rurel Route Number,	
n 24 hours he Funeral pletaly filled edical C		sician: To the best of my knowner: On the basis of examinet end manner steted.						
Ne the	29b. Signeture end title of certifier	must Atall	00	9c. License number		9d. Date signed (Mo		
N	FIRSTYEA 30. Name and address of person who co	k kerrde	NT	1213127	D	ECEMISER	, 51, 200	
1/1	30. Name and address of person who con FIAK ISOR PLOY)	ompleted cause of deeth (item 32. Registrer's Signet	23e) (Type, Print)	MO HAMME	DALA	TTAR	1225	
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Signet	ture 4	1				

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death DECEMBER 30 200 **Physician** FROZEL MASON 9.45 Am 2000 /Medical 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner TMORE SAMALATAN HOSPITAL BALT (roo) If Under 1 Yaar Months Days If Undar 24 Hrs. 5. Social Sacurity Number 8 Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) APRIL 10, 19: Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months 8-50-3072 32 SOUTH Director Usual Residence of Deceden the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits rail, or items 23s or 28s-f show Examiner must be notified at Yes 2 No MARYLAND 10e. Street and Number Directo og. Citizen of What Country? 42 12. Was Decedant Efar in U,S. Armed Forces? 1 — Yes 2 Mo If Yes, Giva Yaar or Dates: 6 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: "natural", or à 3 Widowed 4 □ Divorced nd 2 should be filed within 72 hour sith and Mental Hygiene. 27 is marked other than "natural in traumatic event, the Medical E. Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h, Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) THGRADE PROVIDER 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Surname) . Peges 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth lury or other traumatic even RENNICK HAWKINS JOHN50 19a. Informent's Nama/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MARY BURTON DAUGHTER \$10, BALTO, MO. 21212 WINSTON AVE. 20a. Mathod of Disposition Placa of Disposition (Neme of cemetery, cremetery or other pleca) permit. Peges Department of important: if it any injury or o Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) V 01-06-01 BALTIMORE MARYLAND 22. Name and Address of Facility BROWN JR. FUNERAL HOME 21. Signature of Funaral Servica Licensee 23a. Pert1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest. Approximate Approximate Approximeta Intarval Between Onset and Death **Physician** Immediate Cause (Finet disease or condition rasulting in daath) /Medical LINER CHASTROINTELTINA BLEED Examiner Due to (or es a consequança of): Physician/Medical Examine Duo DENAL ULCER that the deeth certificate be executed Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disaase or Injury that initiated events resulting in death) Lest Due to (or es e consequença of): attending physician and for use as the burial-trer ACTTC ACO EMIA Due to (or es e consequence of): DISTASE ENAL 00 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown by been sig 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Was an autopsy is certificate hes bit director, page 2 st 1 Yes 2 No 1 Yes 2 No Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Dascribe how injury occurred Certification: Injury et Work? After or Attending 1' Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accidant 6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) i 24 hours after on Funeral Directions of Funeral Directions of Funeral Directions of Funeral Property (Filled in Br.) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated. To the Hosp within 24 hou To the Fune completely fi edical (Check only one)

DHMH 16 Rev 6/95

Records,

Division of Vital

State Registrar

29b. Signature and titla of certifier

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

ROSEMARIE MARAI TO GOOD SAMARITAN 31. Data filed (Month, Dey, Year) 32. Registrer's Signeture

W.D

HOSVIMI BALFIMOLE MD 21239

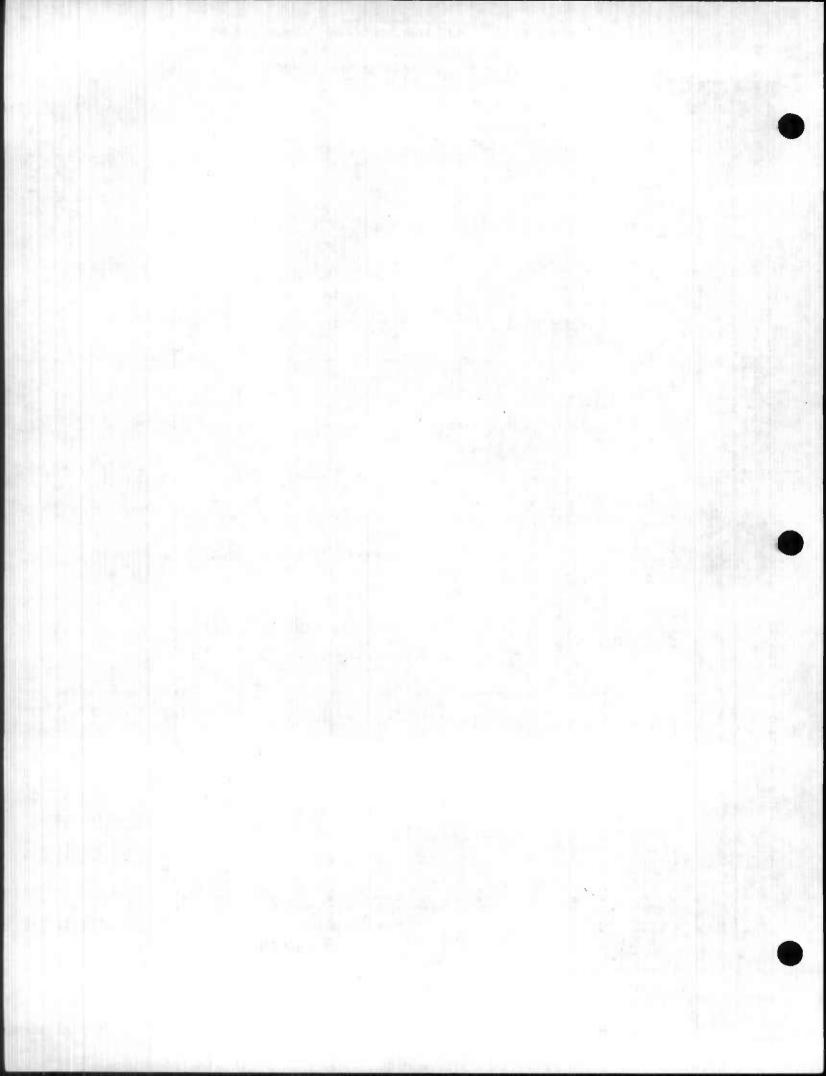
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29d. Date signed (Month, Day, Year)

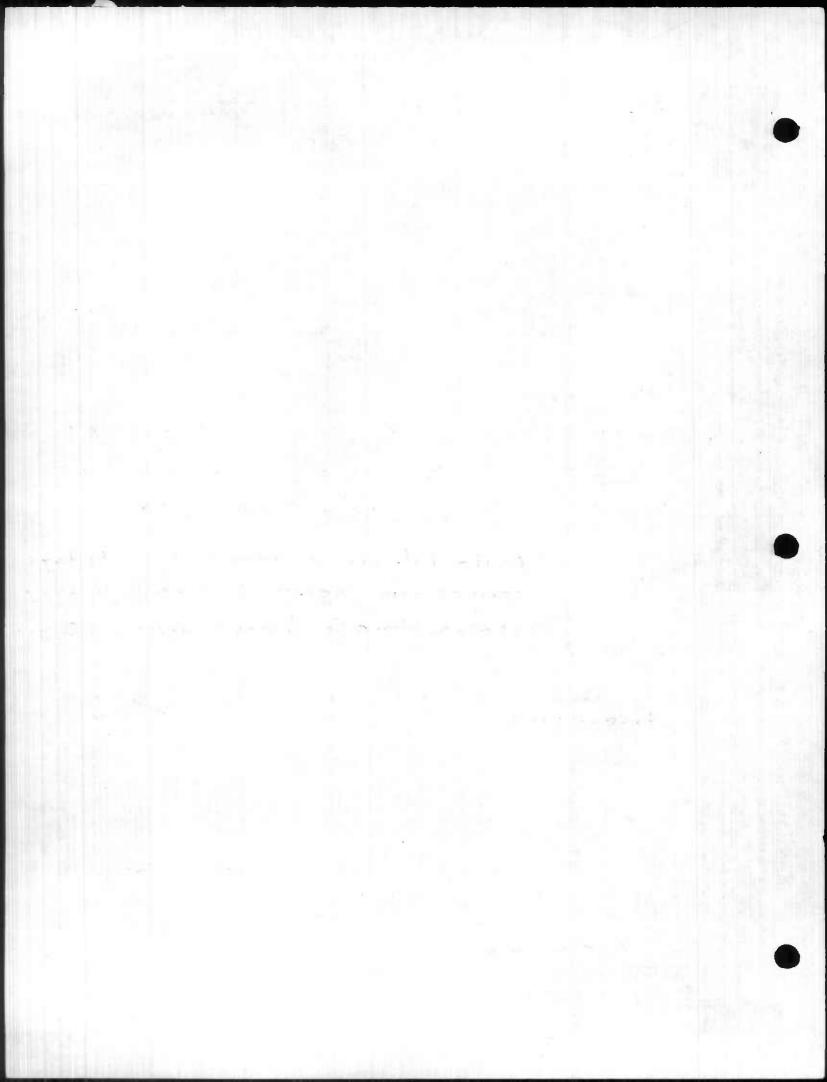
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State of Maryland / Department of Health and Mental Hygiene

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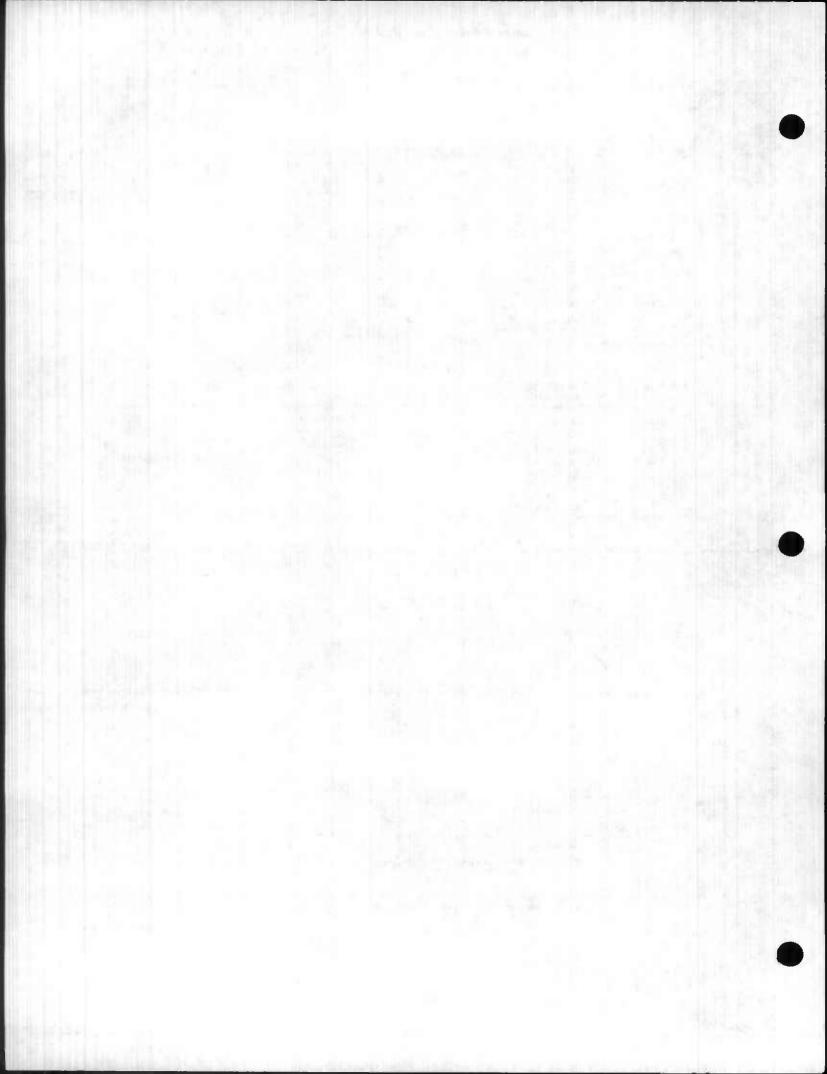


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Iris G. Malczewski 08:30 AM Dec 24 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 807 S. Fagley Street Baltimore USA If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 2 F Months Days Hours 213-32-1596 75 Sep 17, 1925 Director England Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10e. State 10b. County "natural", or items 23a or 28a-f show MD N/A 1 Tores 2 No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after deeth with neat of Health and Mental Hyglena.
ant: if item 27 is marked other than "natural", or freme 23a or ury or other thanmatic avent, it is find that the manual or use or other than the manual or or other than that are the fire that the f USA 807 S. Fagley Street 21224 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Caucasian Aq. 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Self Employed Tavern 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Samuel Alfred Morgan Elizabeth Royals 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Frances Valmas 1803 Bank Street, Baltimore, MD 21231 20e. Method of Disposition

Burial 2 Cremation 3 Removal from State 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o Holy Rosary Cem. 12/28/2000 Baltimore MD 4 Donetion 5 DOther (Specify) 21. Signature of Funeral Service Licenses 22. Neme and Address of Fecility Kaczorowski Funeral Home, P.A. Brauche 1201 Dundalk Avenue, Baltimore, MD 21222 nach ac 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only are cause on each line. Approximete Intervel Between Onset end Death **Physician** eno Carcia Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of) Examine 9 YU attending physicien and I for use as the burial-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or an cionsequence of) P.O. Box 68760 Physician/Medical Due to (or as a consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to completion of ceuse of death? been si 24e. Wes en eutopsy performed? Completed has After this certificate har funeral director, page 1 Yes 2 No 1 □ Yes 2 □ No Division of Vital Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 Other (Specify) 2 After this 28e. Dete of tnjury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attanding Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funera Certification: 28c. Injury at Work? 5 Pending investigation 1 Meturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certified 38 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 0 200 3 200 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 19b per fh G791 1/8/01 yf Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 12-27-2000 Physician William J. Messick 8:00 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2274 Monacracy Road Baltimore Baltimore If Undar 24 Hrs. If Undar 1 Year 8. Data of Birth (Month, Day, Year) 05-29-1920 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Months Days Hours 1 M 2□ F (Country) 219-07-3139 80 Yrs. Director Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23s or 25s-1 show edical Examiner must be notified at 1 Yas 2 No Directo Baltimore Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2274 Monacracy Road 21220 USA Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedant Evar in U.S. Armed Forcas? 14. Race - Amarican Indian, Black White atc. 1 ☐ Yas 2 No If Yas, Giva 1 ☐ Nevar Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Caucasian by 3 Widowad 4 Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) Sheet Metal Mechanic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be William G. Messick Anna Lijewski 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
2274 Monacracy Road, Baltimore, MD 21220 19a. Informant's Name/Ralationship (Type, Print) Mrs. Jessie Messick 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ➡ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) Sacred Heart of Jesus 12-30-00 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Kaczorowski Funeral Home, P.A. Part 1. Enter the disease, or comply amon, that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errast, Approximate shock, or haert failure. List only one cause on each line. Approximata Intarval Batween Onset end Death **Physician** Immediata Causa (Final disease or condition rasulting in death) /Medical 2 mo Non Hodgkin's Lymphomo Examiner an/Medical Examiner attending physician and for use as the bunal-transit The law requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last Due to (or as e consequance of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): Physici signed by the a 23b. Did tobacco use contribute to the cause of death? Part ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by should be 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of cause of death? page 2 s certificate has 1 ☐ Yas 2 PNo 1 ☐ Yas 2 ☐ No neral Director: After this certificate villed in by the funeral director, pr Physician: 25. Was casa rafarrad to medical Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No 2 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Death 28b. Tima of Certification: 28c. Injury at Work? or Attending 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accidant 3 ☐ Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, tactory, office building, atc. (Specify) 4 Homicida edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours within 2

> State Registrar

(Check only

29b. Signatura and titla of certifier

31. Data filed (Month, Day, Year)

JAN

one)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) MIN (M.D.) 6830 HOSPITAL DR # 2000, BALTIMORE, MD 21237

32. Register's Signature 3 2001

m.D

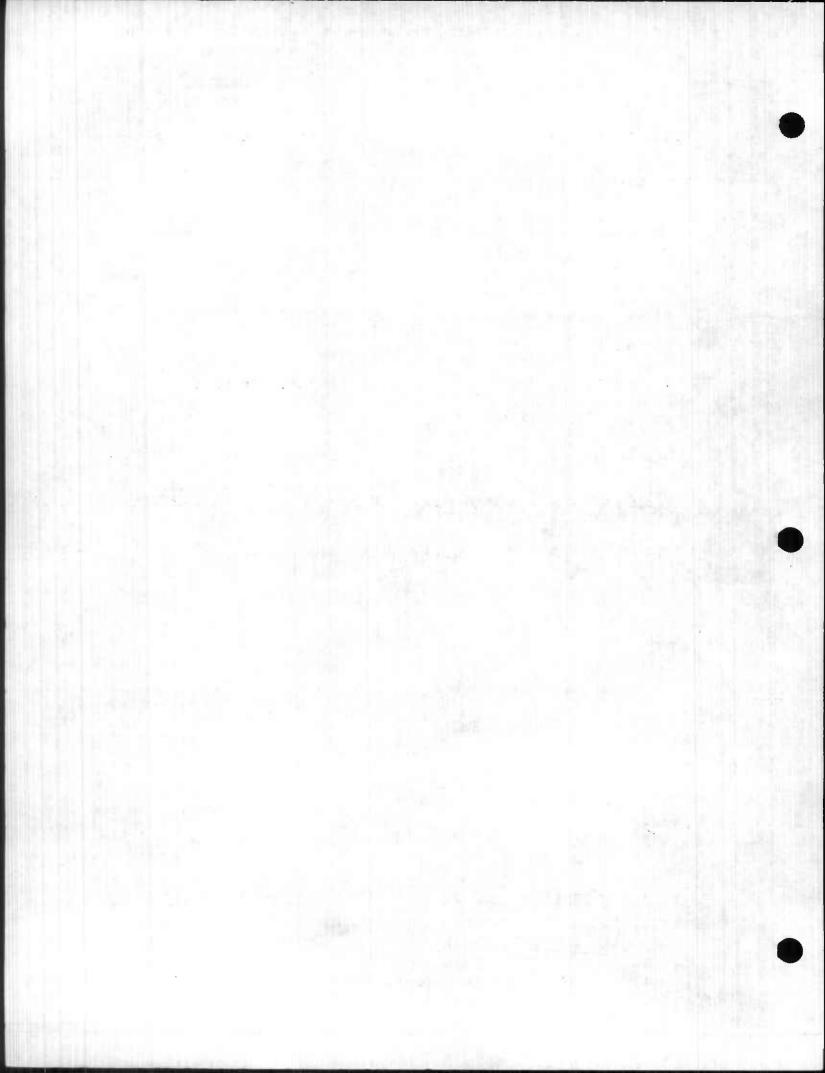
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29c. Licansa number

D 45390

29d. Date signed (Month, Day, Year)

1/2/01



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2000 DECEMBER /Medical 4b. City, Town; or Location of Death 4c. County of Deeth 4e Facility-Name (If not institution, give street and number) Examiner N/A 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 MM 2 F 73 182-22-0382 Pa. 15,1927 Usual Residence of Decedent 10c. City, Town or Location 10a Stete 10h Counts 10d. Inside City Limits 1 ☐ Yes 2 No Director Md Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3468 Liberty Parkway 21222 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 XYes 2 No If Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Supervisor Pepsi Cola 12 yrs. 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Lyda Hicks William Ryland Mattern 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 3428 Yorkway, Dundalk, Md. 21222 William R. Mattern son 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Jan 2 1 ■ Buriel 2 □ Cremetion 3 □ Removel from State Gardens of Faith Cemi 4 ☐ Donetion 5 ☐ Other (Specify) 2001 Rosedale, Md. 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222 23a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth tmmediate Ceuse (Finel diseese or condition resulting in deeth) Due to (or es a consequenca of) Examine DEUMONTA Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 | Yes 2 PNo 3 | Probably 4 | Unknown þ 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 LING 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 (Waturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

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Funeral

Director

with the Meryland

Peges 1 and 2 should be filed within 72 hours after deeth with the Menylan nest of Health and Mentel Hygiene.
ant: If flam 27 Is marked other than "natural", or items 23a or 28a-f ahow ury or other thaumate avant, the Medical Entities must be notified at

permit. Pege Department of Important: If any injury or once.

Physician /Medical

Examiner

altimore, Maryland 21215-0036

edicai

29a. Certifier

31. Dete filed (Month, Dey, Year)

State

29b. Signeture and title of cartifier

3 2001

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.

2 ■ Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29d. Date signed (Month, Dey, Year)

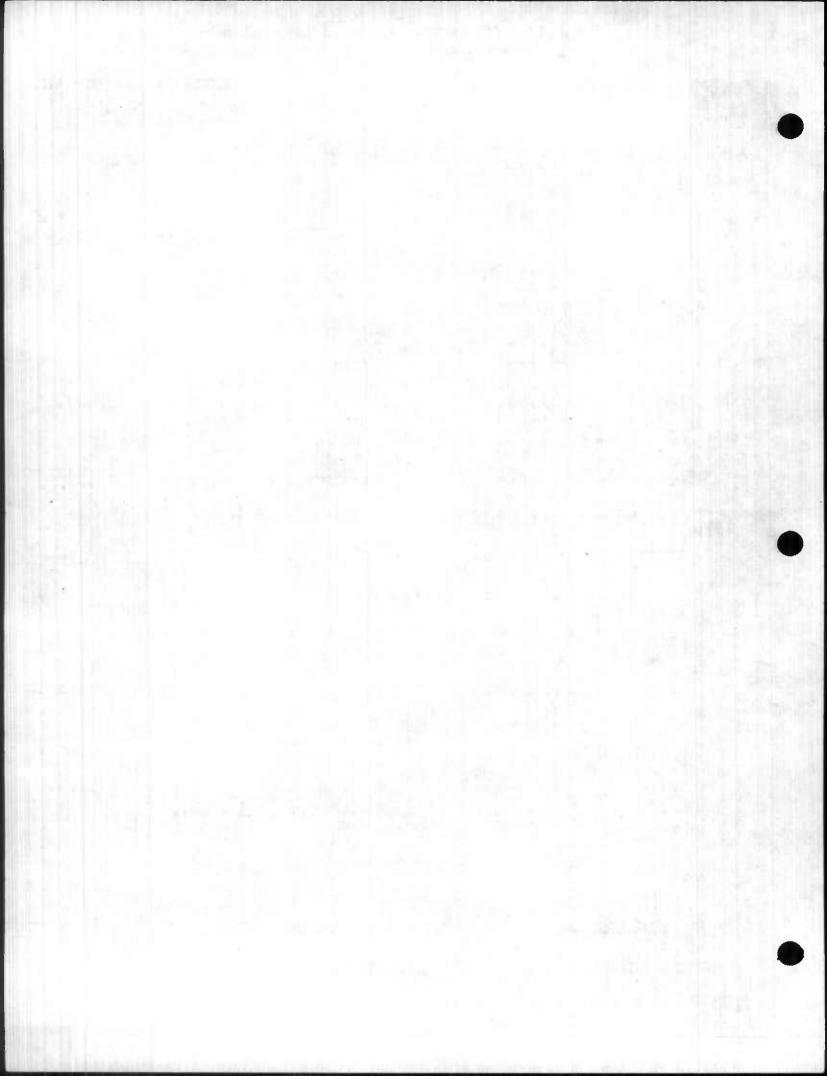
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person who completed cause of deeth (Item 23a) (Type, Print)

KASTERN

32. Registrer's Signeture

parks



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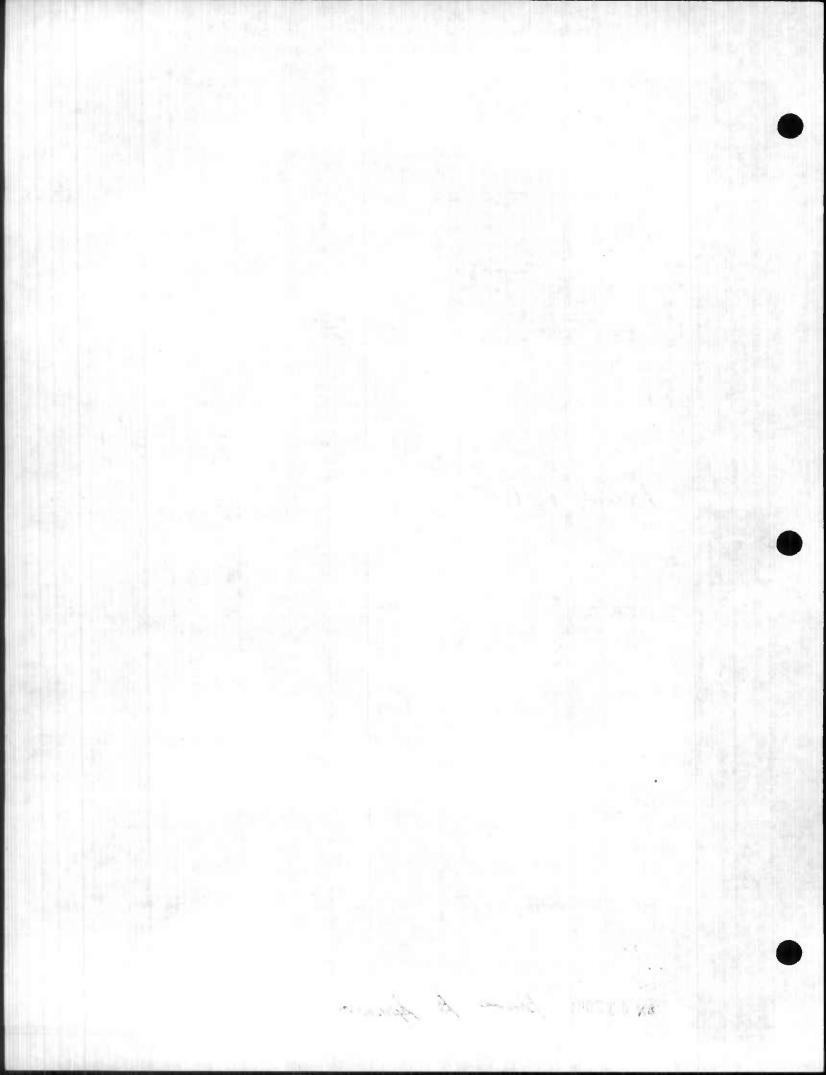
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Charles .						Death		Reg. No.	42000	
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Funeral Director	10e. Street and Number			10f.	Zip Code			10g. Citizen of \	Whet Country?	
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l No	Annette Mucci (V	Vife)						dena, MD.		
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	21. Signeture of Funeral Service Lice	nsee		22. Name	end Addr	ess of Fecility	k Funer	al Home P	λ	
	14116	11:						dena, MD.		
	23a Pant Enter the disease, or com-	plications that caused the	ne deeth. Do no						Approximate Interval Between	000
bunal-transit as bunal-transit as Examiner	Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions,	b	ue to (or es a co	onsequence	of):	HWICE.				
edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or Injury that initiated events resulting in death) Lest	c	ue to (or es e co	onsequence	of):					
Physician/M	Pert II. Other significant conditions	ontributing to death but	not resulting in	the underlying	ng ceuse g	iven in Pert I.			ntributa to the cause of	death?
by P					- 4		- 6	☐ Yes 2☐ No	SETTOMENT 450	TIKSTOWIT
Completed							24a. V	/as en eutopsy erformed?	24b. Were eutopsy fin evailable prior to completion of ce- of death?	
E O							1	☐ Yes 2☑No	1 ☐ Yes 2 €	lo
Be	25. Was cese referred to medical examiner?						Deeth (Check or	ly one)		
2	1 ☐ Yes 2 ☑ No		2 ER/Out		DUA		-	esidence 6 Ott		
lon	27. Menper of Deeth 1 ☑ Natural 5 ☐ Pending investigation	28a. Dete of Injury (Month, Dey	Year) 28b. Ti	me of jury M	28c. Inju	ork? ☐ Yes 2 ☐ No	28d. Descri	be how injury occur	red	
Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	0 00 01 11:	y - At home, fen (Specify)		1		28f. Locatio City or	n (Street end Numi Town, Stete)	ber or Rural Route Numb	<i>⊕г</i> ,
S Ce		ysician: To the best of								
edical	(Check only 2 Medical Examone)	niner: On the basis of e end menner stete		or investiga	tion, in my	opinion, death or	ccurred et the tir	ne, date end plece,	end due to the ceuse(s)	
Ž	29b. Signature and fille of certifier	0	ni	0	29c. Licer	se number			d (Month, Dey, Year)	CAS
X	30. Neme and address of person who	14	oth (Item 23e) (1	Type, Print)		5 (2			
tate	31. Dete filed (Month, Dey, Year)	301 Hos	S Signeture	DR	ME.	Colfa	Bush	HE MI	> 94061	
tate trar	JAN 0 3 2001	1		/						
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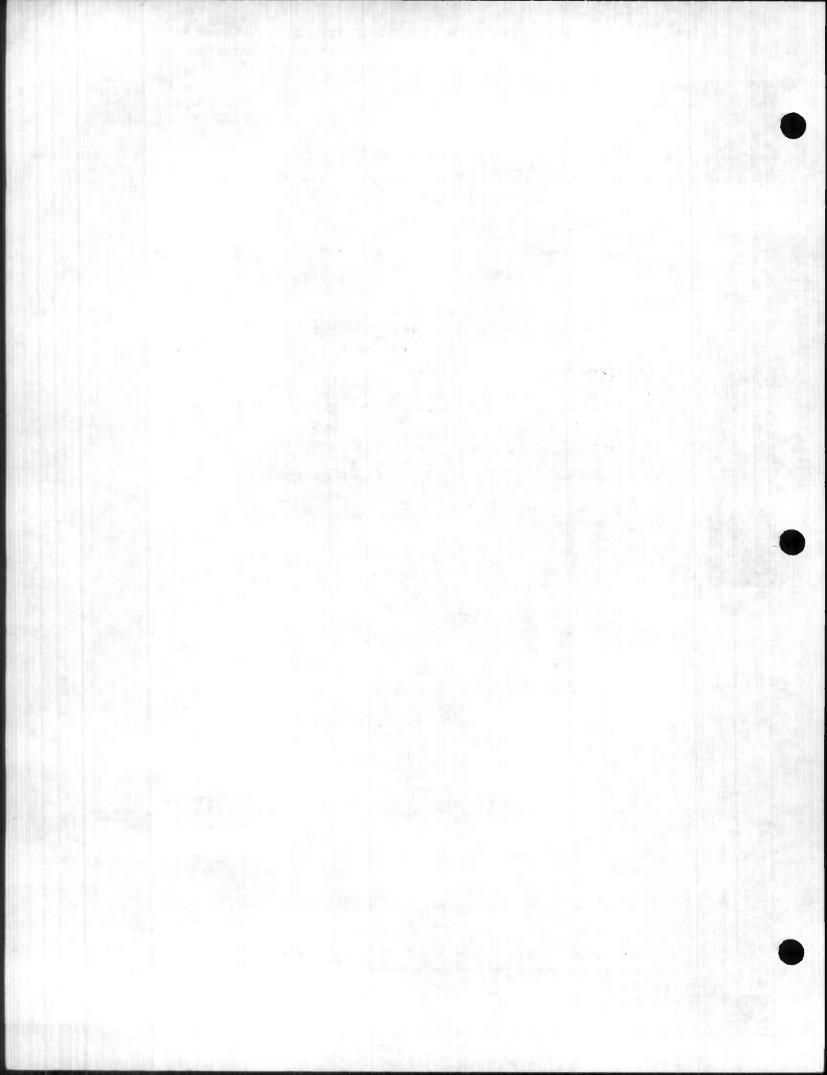
			State of Maryla		partment of ertificate of			ene L	2060
		1. Decedent's Name (First, Middle, L.	ast)				2. Dete of Death		3. Tima of Death
	Physician /Medical	REGINA M.	MIERZEWSKI			4b. City, Town, or	Month DECEMBER Location of Death	Dey Ye 23 2000	5:30 PM
	Examiner	LORIEN NURSING A		מיזוי		BALTIMOR	E	N	/A
	Funeral	5. Sociel Security Number 6.	Sex 7. Age (In yrs	. lest birthda	y) If Under 1 Yas Months Dey	If Under 24 Hrs.			Birthplace (State or Foreign Country)
	Director	Usual Residence of Decedent	1□ M 2□XF 8						ooklyn, N.Y.
	Marylar Med at	Md. 10b. County	n/a 10c. 0	Balti					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-f a be notified Director	10e. Street end Number		19-7	10f. Zip Code		100	. Citizen of What	Country?
	th with wind the same of the s	4415 Parkwood	Ave		212	06		USA	
36	urs after death with the Maryis of theme 23s or 28s-f short Caraliner must be notified at by Furneral Director	11. Maritel Stetus 1 □ Navar Merried 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give A Year or Detas:	U,S. 13	I. Wes Decedent of If Yas, specify Cu	Hispanic Origin? (Suban, Maxican, Puarlo Specify:	pecify Yes or No- o Rican, etc.)		mericen Indien, /hite, etc. White
8		15. Decedent's E	ducetion	16a. Dec	edent's Usuel Occ	upation	16	Bb. Kind of Busine	ess/Industry
21215-0036	ed within 72 ho ygiene, we then 'natural', it the Medical. Completed	(Specify only highest gi	rade completed) College (1-4or 5+)	(Girlife	re kind of work don DO NOT use reti	ne during most of wor red)	rking	Mierzew	ski
21	d with	8	0	Movi	e Ticket	Sales		Deluxe	Theater
Maryland	Wental Hy read other file event	17. Fathar's Nama (First, Middla, Las Walter Kabat	0				ne (First, Middle, Ma ne Strzal)		
lar,	2 aho and 3 auma	19e. Informent's Name/Relationship	(Type, Print)			et and Number or Ru			
-	and n 27		(Daughter)			od Ave, B	7		
ore	T Col H	20a. Method of Disposition 1 □ Buriel 2 ☑ Cremetion 3 [Removal from State	cemetery, c	position (Neme of remetory or other p			oc. Location - City	
Ë	Pag ment:	4 Donetion 5 Other (Special	ify)	reen M		etery 12/	27/2000 1	Baltimor	e Md.
Baltimore	Depart Import any in	21. Signature of Funeral Service Lice	ickell			ress of Facility y—Polynia Patapsco			
	l l	23a. Pert1. Enter the diseese, or cor shock, or heart failure. List only	nplications that caused the dec	eth. Do not e					Approximete Intervel Between
	Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition	· multi-	fret	Demole	77			Onsat and Death
	September 1	I resulting in deeth)			equence of):	5-5-5-5			
	executed in and in-transit		b					Carrie	1
	ta be executed ystolan and he burial-transit ical Examin	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	Due to	(or es e cons	equence of):				
760,	siciar siciar buring	Cause (Disease or injury thet initieted events	C						1
68	as that the death certificating phygened by the attending phybe detached for use as the by Physician/Medit	resulting in deeth) Lest	d.	or es e cons	equence ory:	6 m 30			
Вох	atten for u								
P.O.	the d ny the ached	Pert II. Other significant conditions	contributing to death but not re	sulting in the	underlying ceuse	given in Pert I.	23b. Did tob	20	oute to the causa of death? Probably 4 Unknown
	that the ned by the detach						1 101	2,40 MB 31	Probably 4 Offictions
Division of Vital Records,	should						24e. Wes en performe		4b. Were eutopsy tindings available prior to completion of cause of death?
Re	The lev ate has pege 2						1 ☐ Yes	2 0 No	1 ☐ Yes 2 No
ta	ysician: The last certificate he director, page	25. Wes cese referred to medical				26. Plece of De	ath (Check only one	, (
>	Physician: this certific and director,	examiner?	Hospitel: 1 Inpatient 2	☐ ER/Outpet	ient 3 DOA	Other: 4 Nursing H	foma 5□ Residen	ce 6 DOther (Specify)
o uo	wding Physics the Chiese the function of function of functions	27. Manner of Deeth 1 ANatural 5 Panding 2 Accident Investigation	28e. Date of Injury (Month, Dey Year)	28b. Time Injury	V		28d. Describe hov		
Divis	tallor Attending P Dualter death. at Director: After it led in by the funera Certification:	3 Suicide 6 Could not 4 Homicide determined		home, farm,	street, factory, office	9	28f. Location (Stre City or Town,		r Rurel Route Number,
	the Hospita Din 24 hours the Funeral opistely filled Aedical C	29a. Certifier Certifying P	hysician: To the best of my kn miner: On the basis of examin and menner steted.	owledge, de etion end/or	eth occurred at the investigetion, in m	time, date and plece y opinion, death occu	e, end due to the cau arred at the time, dat	use(s) and manne te and plece, end	or es steted. due to the ceuse(s)
	E STORY	29b. Signature and title of certifier	. /		29c. Lice	nse number	29	d. Date signed (A	fonth, Day, Year)
1		16-14	Cha	190	0	- 1815-1		12-26	N
	40	30. Name and eddress of person who Chi-Shiang Chen					timore, MI	21202	
Ì	State	31. Dete filed (Month, Dev. Year)	32. Registrar's Sig		ocks.	H-TO) Dall	Zmore, fil	, 21202	
	Registrar	.,44 0 0 6001		14					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			Cen	tificate of	Death	Re	g. No.	461	101
	1. Decedent's Neme (First, Middle, Last)		900011		2. Dete of Death Month	Day	Year	3. Time of Death
Physician /Medical	Arthur G. McCart	thy				December		2000	9:23PM
Examiner	4e Fecility Neme (If not institution, give	street end number)			4b. City, Town, or	Location of Death	4c. County	of Death	
	Gilchrist Center				Baltimore	9	N/	/A	
ral tor	5. Social Security Number 6. Se 215-30-2198	7. Age (In	yrs. lest birthday) _ Yrs.	Months Deys			Year) 1934	9. Birthple Count I]]ir	ace (Stete or Foreign ry) NO1S
	Usual Residence of Decedent	100	City Tours at Lea	ation				10	ad Analida Cha Limba
-	10a. Stete 10b. County		. City, Town or Loc	ation				10	od. fnside City Limits 1,
Directo	MD N/A	В	Baltimore					5-	X
	10e. Street and Number			10f. Zip Code		10	g. Citizen of V		ny?
Funeral	5416 Pembroke Ave			21206			U.S.A.		
à	11. Meritel Stetus 1 M Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forcas? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates:		Yes, specify Cu	Hispenic Origin? (S ban, Mexican, Puerl Specify:	pecity Yes or No- to Rican, etc.)		e - America ek, White, e	etc.
ated	15. Decedent's Edu (Specify only highest grad		16a. Decede	ent's Usuel Occi	upation e during most of wor	rkina 1	6b. Kind of Bu	usiness/Indi	ustry
Completed	Elementery/Secondery (0-12)	College (1-4or 5+)			e during most of wor ed)				
000	0		Cat	erer			Food S	ervic	е
90	17. Fether's Neme (First, Middle, Last)					me (First, Middle, Mi	aiden Sumam	10)	
0	Gene McCarthy		ALC: N. LEWIS		Leone C	. Opie			
	19a. Informent's Neme/Reletionship (T	ype, Print)	19b. Mailing	Address (Street	et end Number or Ru	urel Route Number,	City or Town,	Stete, Zip	Code)
	Mark McCarthy- Br	other	3324	Hazelwo	od Drive	Fallston,	Maryl	and 2	1047
	20a. Mathod of Disposition		Ob. Plece of Dispos	ition (Name of etory or other pi	lece)	Date 2	Oc. Location -	City or Tov	wn, State
	1 ☐ Burial 2 ☐ Cremetion 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify)	Removel from State	Gardens o	,		1/5/01 B	altimo	ro M	lanuland
	21. Signeture of Funerel Service Licens			Name end Add		eonard J.R			laryranu
	1000	nea cher c		O5 Harf		Baltimore			21214
	23a. Pert1. Enter the disease, or comp shock, or heert teilure. List only o	lications that caused the						Tanu	Approximete
Medicai Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	b	to (or es e consequ to (or es e consequ to (or es e consequ	rence of):					/
an/M		d					120		
Physician/	Pert fl. Other significant conditions co	ntributing to death but no	t resulting In the un	derlying cause (given in Pert I.	23b. Did tob	acco use co	ntribute to	the cause of death?
						1 🗆 Ye	2 2 (No	3 Prob	nebly 4 Unknown
						24a. Wes en perform	eutopsy ed?	ave	ere autopsy findings eilable prior to inpletion of cause death?
Completed by						1 ☐ Yes	2 DNO	1	Yes 2 No
0	25. Wes case referred to medical	THE RESERVE	- 10-	F1 544 15	26. Plece of De	eth (Check only one			1.7
0 8	exeminer? 1 Yes 2 No	Hospitel:	2 ER/Outpatient	3 DOA	ther	lome 5 ☐ Resider	9 -	er (Specity	Hospica
ation: T	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Yea		28c. In	- 0	28d. Describe how			, 1,0-1,0-
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - building, etc. (Sp	At home, ferm, stre	et, factory, offic	8	28f. Location (Str. City or Town,	eet end Numb Stete)	per or Rural	l Route Number,
edicai		sician: To the best of my ner: On the basis of exar end menner steted.							
ž	29b. Signeture end title of conflier	1	7		nse number	10	d. Date signe		
	Of Hoth	my Kel	en un	1 10-	25205	1	Je cen	rber	31,2000
	30. Neme and address of person who co	ompleted cause of death	(ttern 23a) (Type. F	Print)	-300				, -0
	W. A. Riley	GBMCC	16701	N. Ch	arle St.	Balt	o. md	121.	31,2000 20%
te	31. Dete filed (Month, Day, Year)	32. Registrer's S		, ,					
-	4 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	13 2 3 1		/					

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LRANK MICKOWSK

Many	end 2 sho ealth end h n 27 is me er treume	19a. Informent's Neme/Reletionship (Type Theresa Kopajtic -		19b. Meiling Address (S 1304 Knopp		rettsvi
Baltimore, Man	of He	20e. Method of Disposition 1 X Buriat 2 Cremation 3 Re 4 Donetion 5 Other (Specify)	C	leca of Disposition (Neme emetary, cremetory or othe Moreland Me	r plece)	Date 1/6/01
Balti	pemit. Peg Department Important: I any Injury o pncs.	21. Signeture of Funeral Service Licansee	tool de	Leonard	ddress of Fecility Ba	ltimore Inc. 5
Division of Vital Records, P.O. Box 68760,	Physicien: The lew requires that the death certificate be executed x Mulder this certificate has been signed by the attending physicien end in p p. rel director, page 2 should be deteched for use as the burial-transit a p b c. To Be Completed by Physician/Medical Examiner		Respirator Congestive Coronary Due to (or	rese consequence of): Heart Fars a consequence of): Aftery D es e consequence of):	ilure isease	
s, P.O.	s that the d gned by the se detached	Pert II. Other eignificant conditions control	ibuting to death but not resu	itting in the underlying caus	e given in Part I.	23b. Did
Record	The lew requires the sate has been signed, page 2 should be d					24a. Wes
tal	entifica etor, p	25. Was casa referred to medical			26. Place of Dea	ath (Check only
>	nysicianis cer i direc		ospitel:	ER/Outpatient 3□ DOA	Other	lome 5 Res
o nois	To the Hospital or Attending Physicien: The lev within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		28e. Data of Injury (Month, Day Year)	28b. Time of Injury M	Injury et Work? 1 Yas 2 No	28d. Describe
Divis	tal or Attending Pressure at Director: After the Ind In by the funere Certification:	3 ☐ Suicide 6 ☐ Could nof be determined	28e. Pleca of Injury - At he building, etc. (Specify	ome, ferm, street, factory, o	ffice	28f. Location City or To
	To the Hospital within 24 hours within 24 hours To the Funeral completely filled	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my known: On the basis of axaminat and manner stated.			
2410	Within To the Comp		0	29c. L	icense number	

1. Decedent's Neme (First, Middle, Last)

Maryland General

4a Facility Name (If not institution, give street and number)

10b. County

N/A

1100 Pennsylvania Avenue

15. Decedent's Education (Specify only highest grade completed)

William

1 M 2 F

Frank

5. Social Security Number

216-36-2923

10e. Street and Number

10a. Stete

Maryland

Usual Residence of Decedent

1 □ Never Merried 2 □ Married

3 Widowed 4 Divorced

Elemantary/Secondary (0-12)

8 yr's

17. Fether's Neme (First, Middle, Last) Francis

Physician

/Medical

Examiner

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

Directo

Funeral

by

Completed

the Mendend

death with

uld be filed within 72 hours efter fental flygjena. rked other than "natural", or ite

3. Time of Death

Reg. No. 658 AM

2. Date of Death Month seconder-4b. City, Town, or Location of Death

City

August 2,

31,2000

4c. County of Deeth N/A

8. Date of Birth (Month, Day, Year)

 Birthplece (State or Foreign Country) 1935 Maryland

> 10d. Inside City Limifs 1 Yes 2 □ No

10g. Citizen of What Country?

U.S.A. 14. Raca - American Indien. Black, White, etc.

Specify: White

16b. Kind of Business/Industry

Assembly Line Worker Filter Company 18. Mother's Name (First, Middle, Maiden Sumama)

Ethel Muraro ber, City or Town, Stete, Zip Code)

11e, MD 21084

Belltimore

If Under 24 Hrs.

Hours

Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Yea

Months Deys

10f. Zip Code

21201

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Milkowski

10c. City, Town or Location

Apt. 1303

Baltimore City

7. Age (In yrs. last birthdey)

Hospital

65

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes, 2 W No If Yes, Give Year or Detes:

Collega (1-4or 5+)

Milkowski

20c. Location - City or Town, State Baltimore, MD

MD 21214

305 Harford Rd.

Approximete Interval Between Onsat and Death

tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown

> 24b. Wara autopsy findings available prior to completion of cause of death? s en eutopsy lormed?

2 1 No Yes 1 ☐ Yas 2 ☐ No

one)

idence 6 Othar (Specify) how injury occurred

(Street end Number or Rural Route Number,

e ceuse(s) end menner es stated. e, deta and placa, end due to the ceuse(s)

29d. Date signed (Month, Dey, Year)

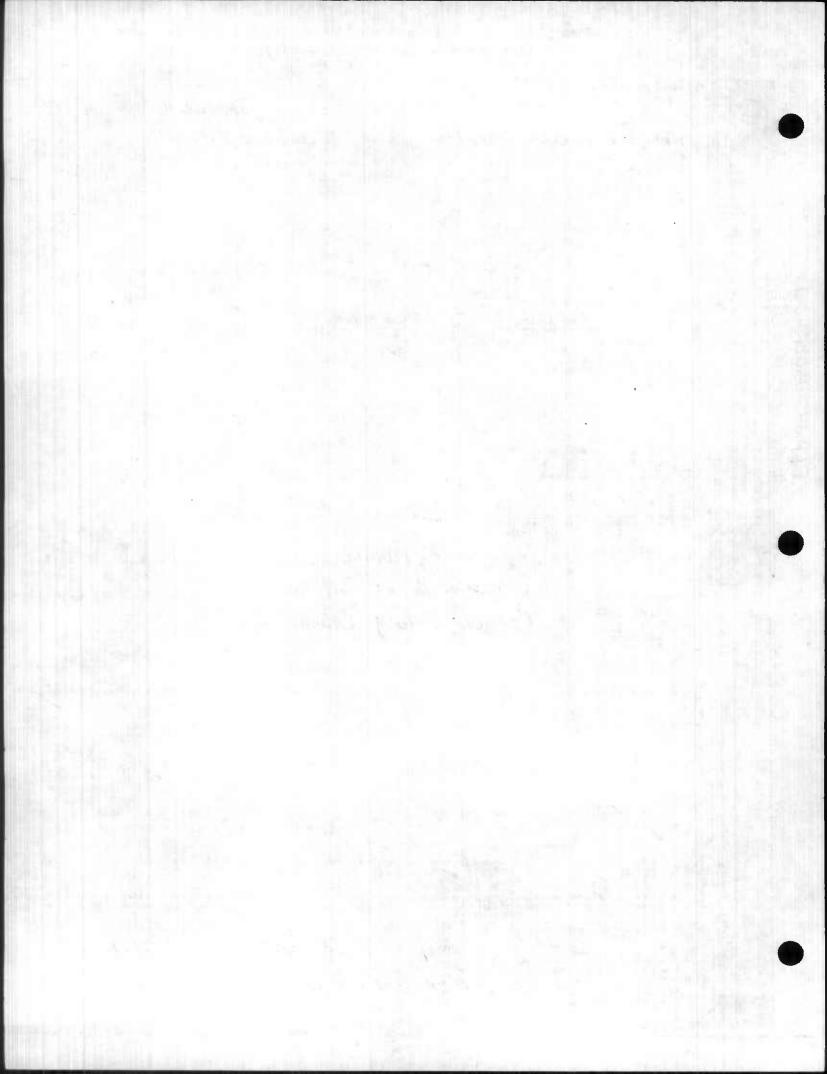
30. Name and addrass of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

DHMH 16 Rev 6/95

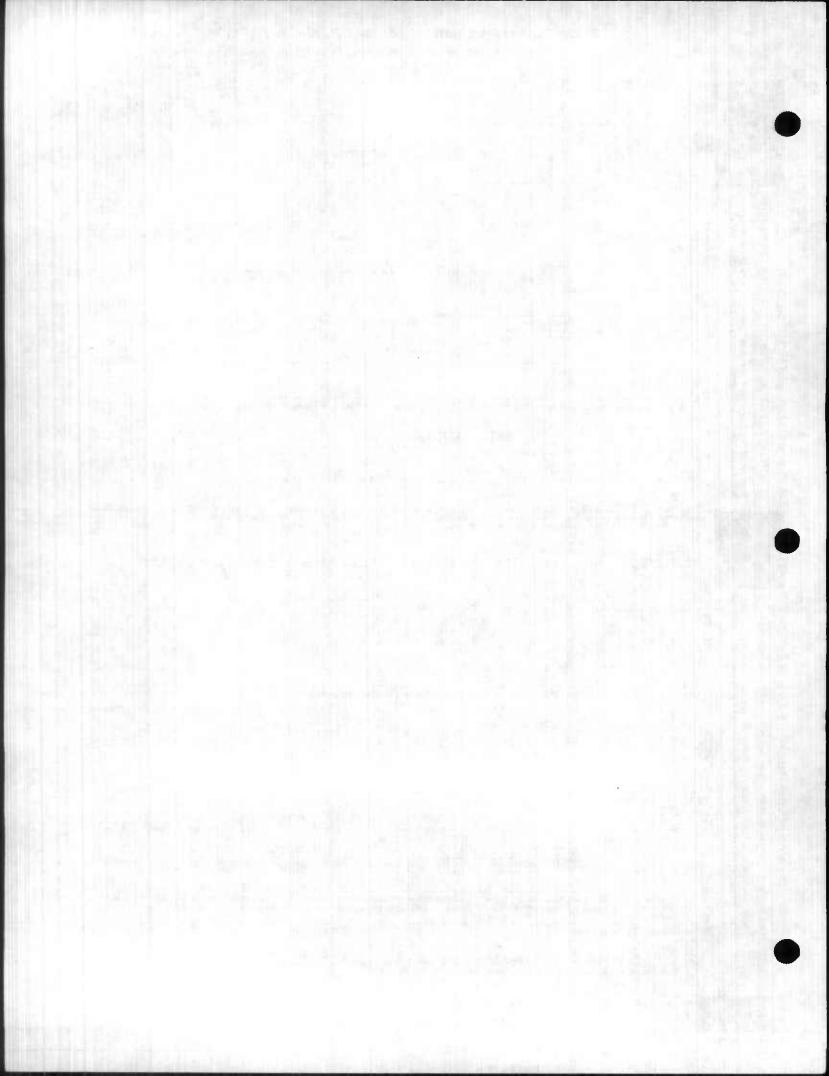
State Registrar

ORIGINAL



State of Maryland / Department of Health and Mental	Hygiene 1	1	2	1
Certificate of Death	Reg. No.		1 600	9

THE RESERVE OF THE PARTY OF THE	1. Decedent'a Name (First, Middle, Last)		Certificate of		2. Dete of Death Month	Day Year	3. Time of Death
Physician /Medical Examiner	Julia Mary Manci 4e Facility Neme (If not institution, give s Stella Maris Hosp	street end number)		4b. City, Town, or Loc Timonium	December		eth
Funeral Director	5. Social Security Number 6. Sex		birthdey) If Under 1 Yeer Months Days	If Under 24 Hrs.	8. Dete of Birth (Month, Pay, Y June 27	-	thologo /State or Foreig
how How	Usual Residence of Decedent 10a. State 10b. County MD Baltimo		own or Location				10d. Inside City Limit
riter death with the maryland riter must be notified at Your rest Director	10e. Street and Number 2804 Kings Ridge Ro	nic 20 states	10f. Zip Code 21234			. Citizen of Whet C	ountry?
Fu by Fu	11. Meritel Stetus 1 Never Married 2 Married	12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	13. Was Decedent of If Yes, specify Cut	Hispenic Origin? (Specien, Mexicen, Puerto F	cify Yes or No- lican, etc.)	14. Race - Am Black, Whi Specify: W	
ygiena. ner than "naturi nt, fr. Walcall	15. Decedent's Educ (Specify only highest grade Elementery/Secondary (0-12)		6e. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	9	b. Kind of Business	"Eigyill
th and Mental Hygiene. The marked other than " fraumatic event, or the To Be Compil	17. Fether's Name (First, Middle, Last) John Wojciechowsk		Manager	18. Mother's Neme Mary Druz	(First, Middle, Ma		anufacturin
attending physician and attend	20e. Method of Disposition 1 Burial 2 Cremetion 3 R 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complishock, or heart feilure. List only or Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last	emoval from Stete Holy The Heather Cain Cations that caused the deeth. It is caused on each line. Due to (or as but to (or es to come and to the course)		tery 1, ess of Facility Lec ford Road E ing, such es cerdiac or	73/01 Du onard J. Baltimore respiretory erres	t,	aryland c.
C 3 E	Part II. Other eignificant conditions con	tributing to death but not resultin	ng in the underlying cause g	iven in Pert I.			te to the cause of deat
y the atter ached for a					240 18/00 00		Were eutopsy findings aveilable prior to completion of cause
been signed by the attershould be detached for the letter of the letter					performe		of death?
ate has been signed by the atterpage 2 should be detached for a Completed by Physicial	25. Wes case referred to medical	lospitel: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3□ DOA	26. Plece of Death her: 4 2 Hoursing Hom	performe 1 □ Yes (Check only one)	2 2 No	of death? 1 Yes 2 No
After this certificate has been signed by the atteitureral director, page 2 should be detached for a form. To Be Completed by Physicial	25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home	b. Time of Injury M 1	her: 4 A Nursing Hom bry et brk?] Yes 2 No	performe 1 Yes (Check only one) 1 Sesident 1 Pescribe how 1 Pescribe how	2 ☑ No ce 6 □ Other (Sp Injury occurred	of death? 1 Yes 2 No
A hours after deeth. Funeral Director: After this certificate has been signed by the attertal precion of the funeral director, page 2 should be detached for a talfiffication: To Be Completed by Physicial	25. Wes case referred to medical examiner? 1 Yes 2 100 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phys (Check only 2 Medicat Examine)	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) ilclan: To the best of my knowled the control of the basis of examinetion	ib. Time of Injury M 28c. Injury M 1 [28c. Injury M 1] b, farm, street, factory, office dge, deeth occurred et the texture of	her: 4	performe 1 Yes (Check only one) 1 Sesident 8d. Describe how 8f. Location (Stre City or Town,	2 ☑ No ce 6 □ Other (Sp r Injury occurred set and Number or It State)	of death? 1 Yes 2 No ecity) Rurel Route Number,
or maining ripsidan. The law requires that the death. Director: After this certificate has been signed by the atter in by the funeral director, page 2 should be detached for a entification: To Be Completed by Physicial	25. Wes case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physical examples of the control of the	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify)	ib. Time of Injury M 28c. Injury M 10. farm, street, factory, office dge, deeth occurred et the tand/or investigation, In my 29c. Licen	her: 4	performe 1 Yes (Check only one) 1 Sesiden 1 Sesiden 2 Sesiden 3 Sesiden 3 Sesiden 3 Sesiden 4 Sesiden 5 Sesiden 6 Ses	2 ☑ No ce 6 □ Other (Sp r Injury occurred set and Number or It State)	of death? 1 Yes 2 No ecity) Rurel Route Number, as stated. as to the ceuse(s)



			State of	Maryland / I			Death	u Mentai n	Reg. No.	420	04
Physic	ian	1. Decedant's Nama (First, Middla, I Robert John						2. Data of I			3. Tima of Death
/Med Exami	cal	4a Facility Neme (If not institution, g Howard County		nber)			4b. City, Town,	Decemb or Location of Dec nbia	ath 4c. County		7:50am
Funera Director		216-64-3812	. Sex 1 M 2 □ F	7. Aga (In yrs. last bi	BA-	Under 1 Yaa onths Deys		Ain (AAnneh (Sirth Year) 5, 1954	9. Birthplac Country Virgi	ca (Stata or Foraign) .nia
Maryland a-f ahow	tor	Usuel Rasidence of Decedant 10a. Stata 10b. County Maryland Howa	rd	10c. City, Tow	m or Localio Columb					10d	. Inside City Limits 1 ☐ Yas 2 No
or 284	lrec	10e. Street and Number			10	Of. Zip Code			10g. Citizen of V	What Country	n
th wil	20 00	6019 Wild Ging	er Court			2	1044		U.S	.A.	
*natural", or frame 23a or 28a-f ahow	by Funeral Director	11. Merifal Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	Armed For	2 🔼 No a	If Yas	Decedent of s, specify Cu res 2 No	ban, Maxican, P	? (Specify Yes or t uarto Rican, atc.)	Blac	e - Amarican ck, White, at w: Whit	
72	Be Completed	15. Decedant's (Specify only highest of Elemantery/Secondery (0-12)			(Giva kind life. DO N	S Usuel Occu of work done IOT usa ratir	a during most of ed)	working	16b. Kind of B	usinass/Indu	stry
of 2 should be filed within the and Mental Hygiene. 7 Is marked other than treumstic event, treumstic event, treumstice.	To Be Co	17. Felher's Neme (First, Middle, La Robert McHenry				. IIVCI.	18. Mothar's	Name (First, Midd e M. Pot	la, Maiden Suman	A	
172 a 172		19a. Informant's Name/Ralationship Kristine McHen		e 60	019 Wi	ld Gi		rt Colu	mbia, Ma	ryland	21044
mit Pages 1 ar partment of Hea cortant: if them ?		20a. Mathod of Disposition 1 □ Burial 2 🖾 Cramation 3 4 □ Donation 5 □ Other (Special Content of the Conten	cify)	stata .	ry, cramator	y or othar pl	ace) natory	Jan 4, 2001	Laure	City or Town	
Depart Depart Import any in		21. Signature of Funeral Service Lie	26	who s	1630	Edmo		renue Ca		e,Mary	land 212
Physician /Medical		23a. Part1. Entar the disease of coshock, or haart failura. Immediate Cause (Final disease or condition	Λ	<			ring, such es car	diec or respiratory	arrest,	1. 6	pproximata ntarval Batween basef end Death
Examiner	Jer	resulting in death)	a	Dua to (or as a	consequence	ca of):		all had		1	h-
be exacuted ician and burial-transit	I Examiner	Sequentially list conditions, if eny, leading to immediata cause. Entar Undarlying Cause (Dissess or injury	b. 100	Dua to (or ws a	consequant	e of):					Typ.
certificate ding phys	VMedica	that initiated evants resulting in death) Last	d	Due to (or es e	consequanc	e of):				1	
hat the do dotached	Physician/Medical	Part II. Other significant conditions	contributing to de	ath but not rasulting i	in tha undari	ying cause g	iven in Part I.		d tobacco use co □ Yes 2□ No		he cause of death?
requir been s should	Completed by								es en autopsy rformed?	evaile	autopsy findings able prior to pletion of cause eth?
F								/	¥as 2□No	10	Yas 2 No
Physician: The rhis certificate and director, pag	Be	25. Was casa refarred to medical examinar?	Hospital:				ther:	Death (Check only		40. 41.	
를 를 줄	1: To	1 ☐ Yas 2 ☐ No 27. Manner of Deeth	28a. Data d	npatient 2 ER/O	utpatient 3 Tima of	L DOA	4 LI Nursir		sidence 6 Oth e how injury occur		
tending leath. tor: After the fune	fleation:	1 Statural 5 Panding 2 Accident invastigat 3 Suicide 6 Could not	(Monti	h, Day Year)	Injury A		☐Yes 2☐No			2-1-0	Poute Number
De ca	=	4 Homicide detarmine	d 28e. Placa	of Injury - At homa, for	arm, street, f	ractory, office	9		(Street and Numl Town, State)	er or Hural F	route Number,

To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury · At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 29e. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29d. Data signed (Month, Day, Year) 29c, License number

30. Neme and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

| OST LIFFE

31. Data filed (Month, Day, Year)

JAN 0 3 2001

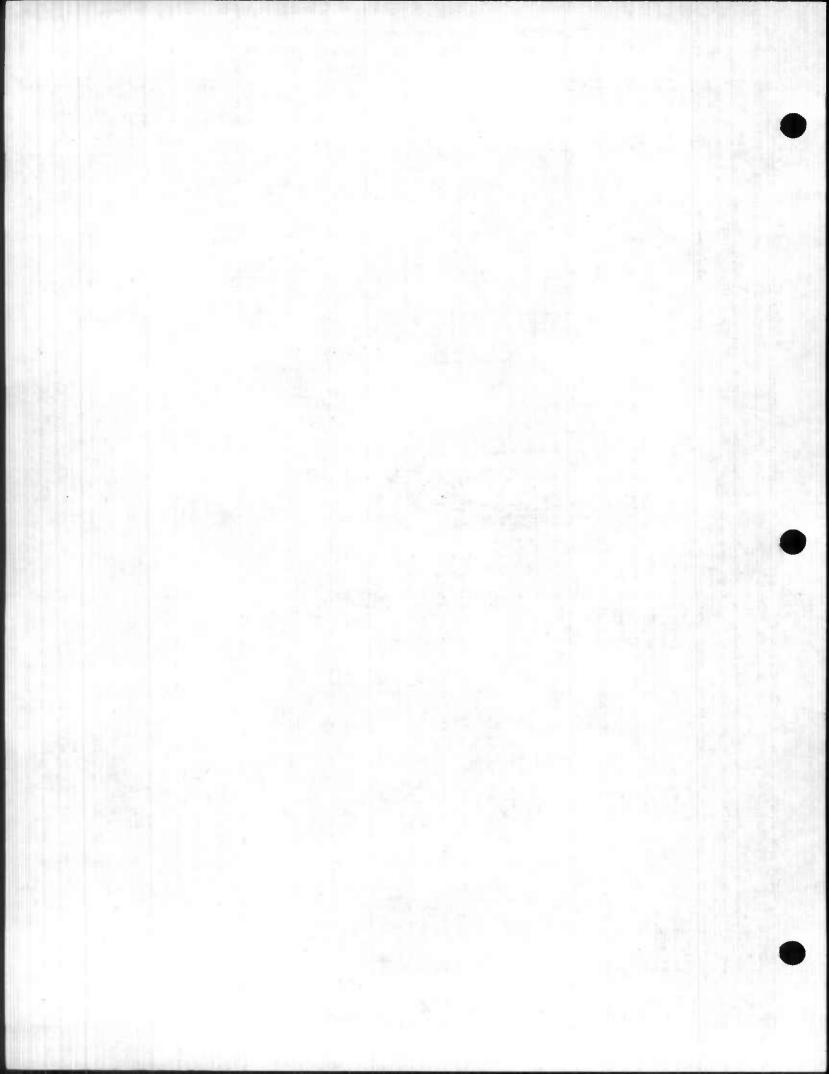
32. Registrar's Signature

33. Apa

Popus PL Colubro, mo znegy

State Registrar

Medical Certifica



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Laughlin recomber 30,20007:25 AM DYF/ND. /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner 2715 - 2nd. Avenue, Baltimore Baltimore 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 6. Sex 1 ☑ M 2 ☐ F 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** Months Deys Yrs. 326-01-4749 98 Director Oct. 09, 1902 Illinois Usuel Residence of Deceden the Manyland 10e, Stete 10c. City. Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28a-f show traumatic event, the Modeal Examiner must be notified at MD Baltimore Baltimore 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? deeth with 2715 Second Avenue 21234 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes: 11. Marital Slatus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. permit. Pages 1 end 2 should be flied within 72 hours efter of Department of Health and Mental Hygiene. If them 27 is merked other than "natural", or feer eny Injury or other traumetic event. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) International Supervisory U.S.Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John McLaughlin Catherine Ward 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2715 Second Avenue, Baltimore, Maryland 21234 Mary K. McLaughlin- Daughter 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Commetery, Crometory or other place)
Hillcrest Memorial Gardens 2001 Leesburg, Florida 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Witzke Funeral Homeof Columbia 21. Signature of Funeral Service Licensee 5555 Twin Knolls Road, Columbia, Maryland 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel eriosc levolic disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner SCUla buriei-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest pue Due to (or es e consequenca of) physician 90 Physician/Medical the Due to (or es e consequence of): use as 0 signed by the a Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? PO 3 Probably 4 ☐ Uplenown 1 Yes 2 No Division of Vital Records. by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peeu has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) examine 1 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Certification: To funeral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one) To the To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -09383 130,2000 onne 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) /// Hamle THIIRd

ONNe/

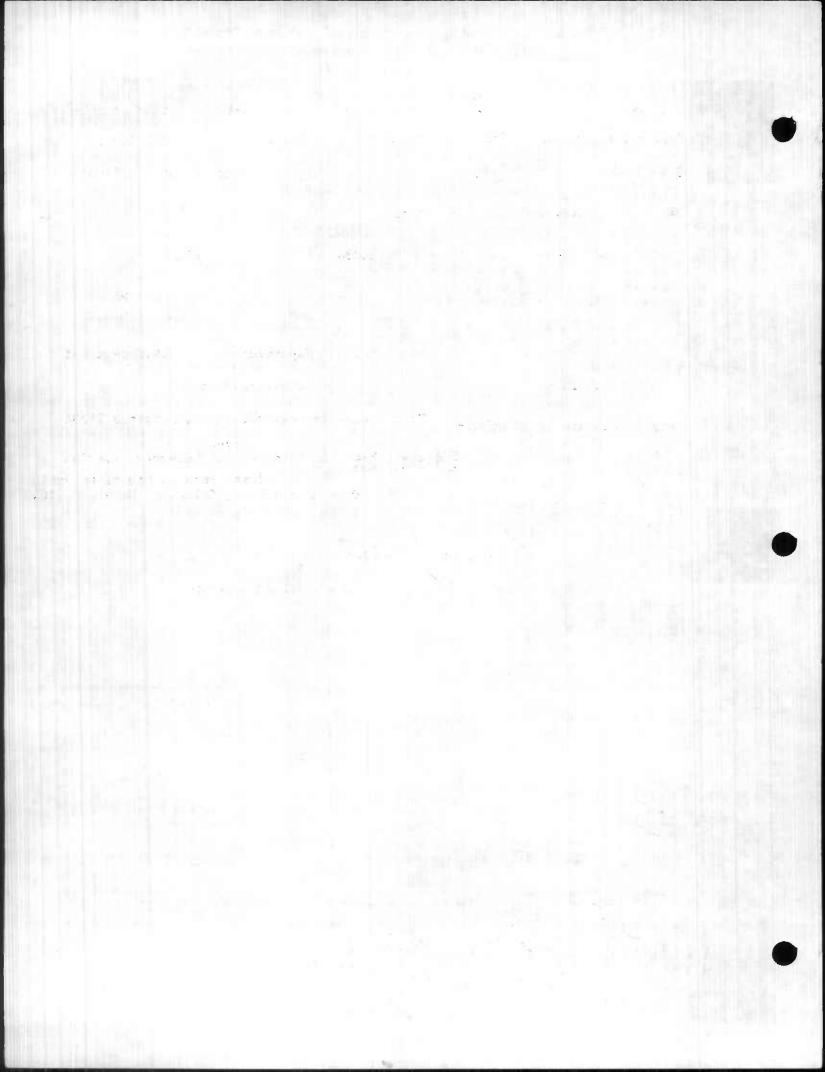
32. Registrer's Signature

132/timere

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DHMH 16 Rev 6/95

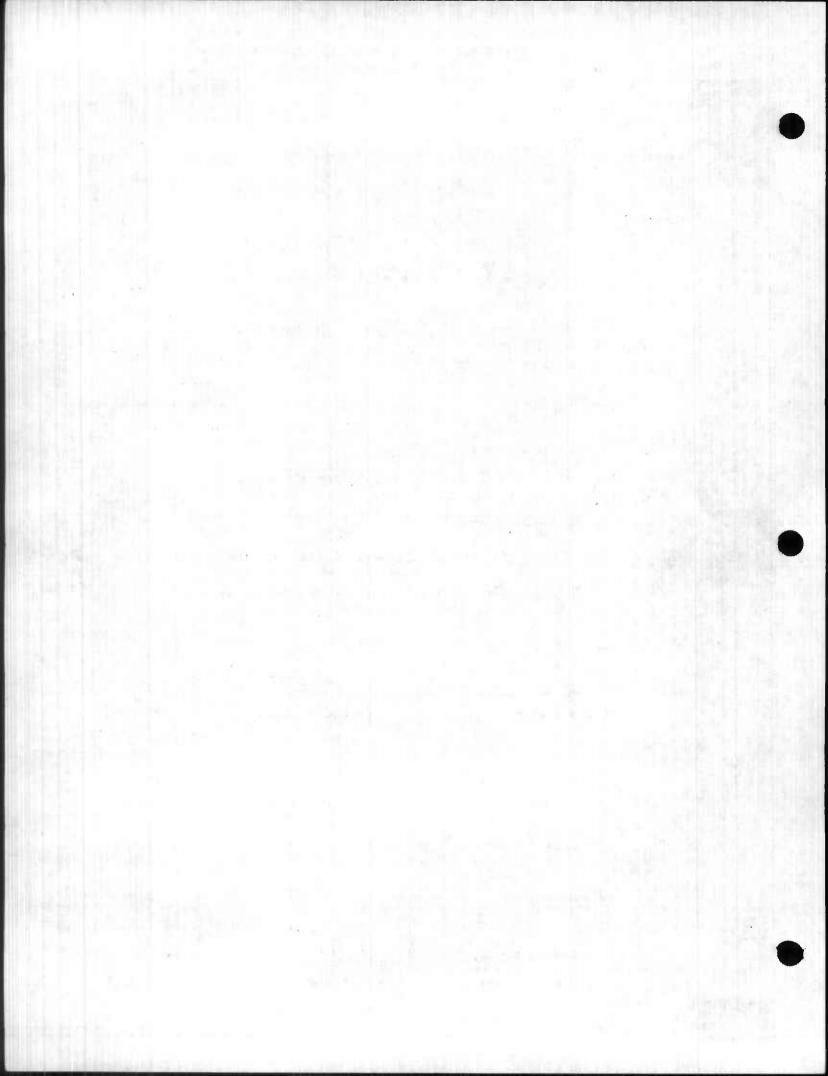
State Registrar



Amended	State of Item#4bmperPHYG791 1/3/2001 EW	Maryland / Depa	artment of F <i>rtificate of</i>			iene	2066
Physician	1. Decedent's Name (First, Middle, Last) Mary S. Milheim				2. Date of Death Month Decembe:	Day Yo	3. Time of Death 00 5 P.M.
/Medical Examiner	4a Facility Name (If not institution, give street and num Eastpoint Nursing Home	nber)		4b. City, Town, or Lo	cation of Death	4c. County of	Death
Funeral Director		7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 4,	Year)	Birthplace (State or Foreign Country) ennsylvania
2	Usual Residence of Decedent 10e. State 10b. County	10c. City, Town or Le	neation		<i>Dec.</i> 4,	1710	10d. Inside City Limits
the Maryland 28s-f show notified at rector	Maryland n/a	Baltimo					1 🕱 Yes 2 🗆 No
4 8 B	10e. Street and Number 3706 East Lombard Street		10f. Zip Code 21 22 4		10	og. Citizen of Wha	
5-0036 72 hours after death vinelunits, or thems 23a dical Examiner must	11. Marifal Status 1 Navar Married 2 Married 1 Yes 1 Navar Married 2 Married 1 Yes 1 Xwas Dece	ces? 21 No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗓 No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, While, atc. White
Baitimore, Maryland 21215-0036 semit. Pages 1 and 2 about be filled within 72 hours all hopefunant of behavioral byderivations of the semith and Mental Hydron processes, in service other than "setural", or my injury or other traumatic event, the Medical Examinate. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-	-4or 5+) (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of worki	ing	16b. Kind of Busin	ess/Industry Home
yland 2 ould be filed Mental Hygi erked other affic event, I	17. Father's Name (First, Middle, Last) Stephen Baidy			18. Mother's Name		faiden Sumame)	
S should be and Menta is merked summeric or To B	19a. Informant's Name/Relationship (Type, Print)	19b. Maill	ing Address (Street	and Number or Rura	I Route Number,	City or Town, Sta	ate, Zip Code)
or other tr	Elizabeth Fetterman (Daug 20a. Method of Disposition 1	20b. Place of Disponentate	matory or other pla	се)	Date	faryland 20c. Location - Cit	y or Town, State
Baltimo	4 □ Donation 5 □ Other (Specify) 21. Signatura of Funera) Servica Licensee		Cemetery 2. Name and Addre	L			, Maryland
BB Per	Folint frada	2	134 Willo	nton-Matt w Spring	Road Du	ındalk, N	
Physician	23a. Part1. Enter the disease, or complications that ce shock, or heart failure. List only one cause on each	bused the death. Do not an ach line.	lar tha moda of dyi	ng, such as cardiac d	or respiratory arre	est,	Approximata Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	LUTE CO	NGEST	VE HE	ART F	AILUR	E DAYS
The second second		Due to (or as a conse		ERY 7	LIEAS	E	YEARS
8760, sate be executed hystician and the buriel-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last	Due to (or as a consecutive to (or a)	quence of):		7.007.0		
P.O. Box 6(at the deeth cartific, by the attending p atached for use es: Physician/Mec	d	Limit of the					
P.O. Box 6 that the deeth cartification of datached for use as	Part II. Other eignificant conditions contributing to de	ath but not resulting in the u	underlying ceuse gi	ven in Part I.	23b. Did to	bacco use contri	bute to the cause of death?
ss that the de igned by the detached by Physic	ARTERIOSE	LEROTIC	HEAR	T DISEASE	1 Y	2 D No 3	Probably 4 Unknown
Cord					24a. Was a parform		24b. Were autopsy findings available prior to completion of ceuse of death?
f Vital Reconstructions to be completed by the law of the conficult of the complete by the confidence by					1 □ Y€	s 2 TNo	1 ☐ Yas 2 ☐ No
hysician: The hysician: The his certificate il director, pag	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 I I	npatient 2 ER/Outpatie	ent 3 DOA Ot	26. Place of Death		e) once 6 Other	(Spacify)
Vision of Attending Physical desth. ector: Attenthis by the funeral diffication: To		f Injury b, Day Year) 28b. Time of Injury	of 28c. Inju			ow injury occurred	
Division of Atlanding P as after death. In pretor, After the in by the funers Certification:	3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm, st g, etc. (Specify)	reet, factory, office		281. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
Frank Son	29a. Certifier (Check only one) 1 Certifying Physician: To the ba and mann	sis of axamination and/or in					
To the growth was a Mee	29b. Signature and title of certifier) WDPA	29c. Licen	1366 4		2	Month, Day, Year)
Del)	30. Nama and addrass of person who completed cause B. C. VENERACION J		, Print)		VD 6	BALTO M	2000
State Registrar		egistrar's Signatura	3 1	oaks)		-1	MARIE .

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Dev Year MARTICK SHIRLEY 29th 2000 09:35 DECEMBER 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE If Under 24 Hrs. If Under 1 Year 8. Data of Birth Month, Day Year SEP. 6, 1916 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 M 2XX Months Hours Yrs. 84 217-96-9357 UKRAINE Usual Residence of Decedeni 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□ Yes 2No BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 AVERS COURT 21136 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Was Decedent Ever in U,S. Armed Forces? Black, Whita, atc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2XXNo Specify: WHITE Specify: 3)((Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER REAL ESTATE 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) SHOCKETT PHILLIP IDA (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 E. Lexington St. #1414 - Baltimore, Md 21202 STEVEN SHOCKETT / Nephew 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stala 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RODFE ZEDEK CONGREGATION 12/31/00 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Pages 1 and 2 should be in ment of Health and Mental H ant: If them 27 is marked off lury or other traumatic ever

Physician

/Medical

Examiner

10a. Stata

Directo

Funeral

by

Completed

Be

2

MD

Funeral

Director

28e-f

or Items 23s or maint be

the Maryland

filed within 72 hours after

altimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

Attending Physician: The law requires that the death certificate be executed

physician and the burial-transit funeral director,

Examiner Physician/Medical by Be Completed

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart failura. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death)

certificate this Affer Hospital or Attending
 24 hours after death.
 Funeral Director: Aft filled in by To the Hosp within 24 hos To the Fune completely fi

signed by the attending p

Certification: To

Medical State Registrar

1 Yes 2 No 27. Manner of Death 1 Natural

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signatura and title of certifier

Horna

5 Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

cuerday m.D

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28c. Injury at Work? 1 TYes 2 TNo

maryland

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed?

1 Yas 2 No

28d. Describe how injury occurred

29c. License number D64730

Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) DECEMBER 29th 2000

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Approximata Interval Between Onsat and Daath

3 weeks

3 weeks

24b. Were autopsy findings available prior to completion of causa of death?

1 Yas 2 No

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Baltimore

2434 W. Belvedere . Avenue 31. Data filed (Month, Day, Year)

JAN 03

32. Registrar's Signatura

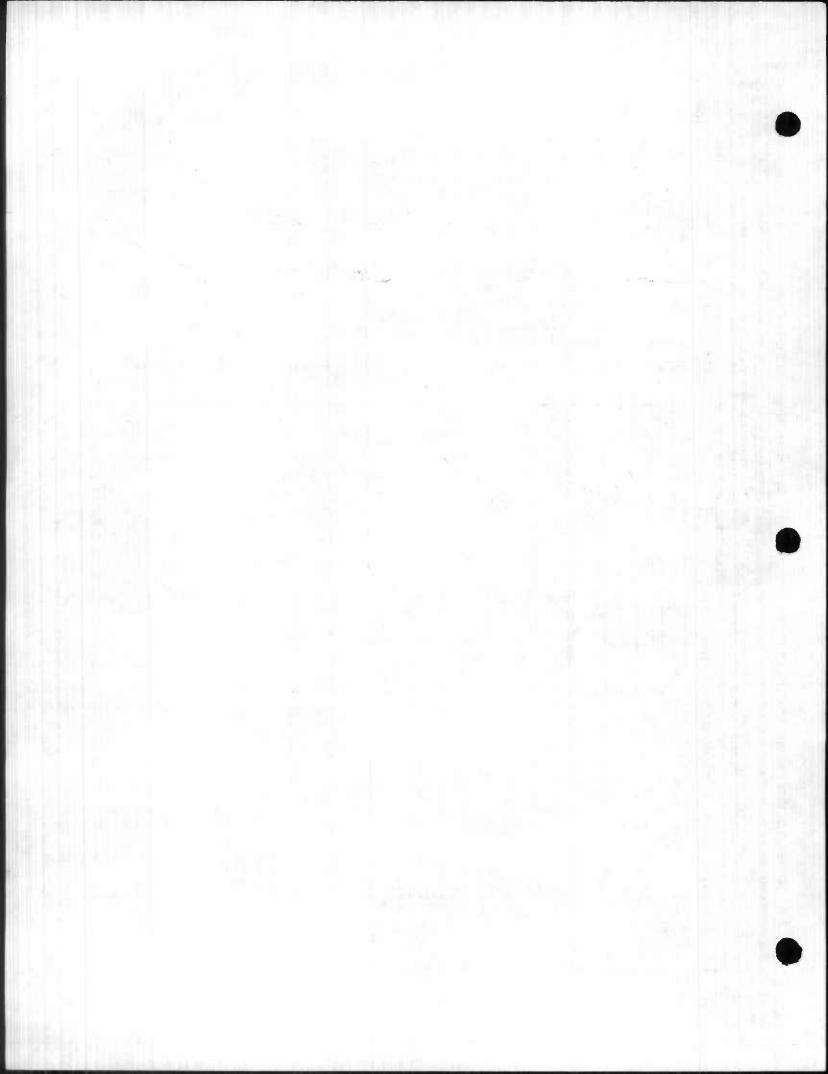
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Due to (or as a consequence of):

Due to (or as a consequence of):

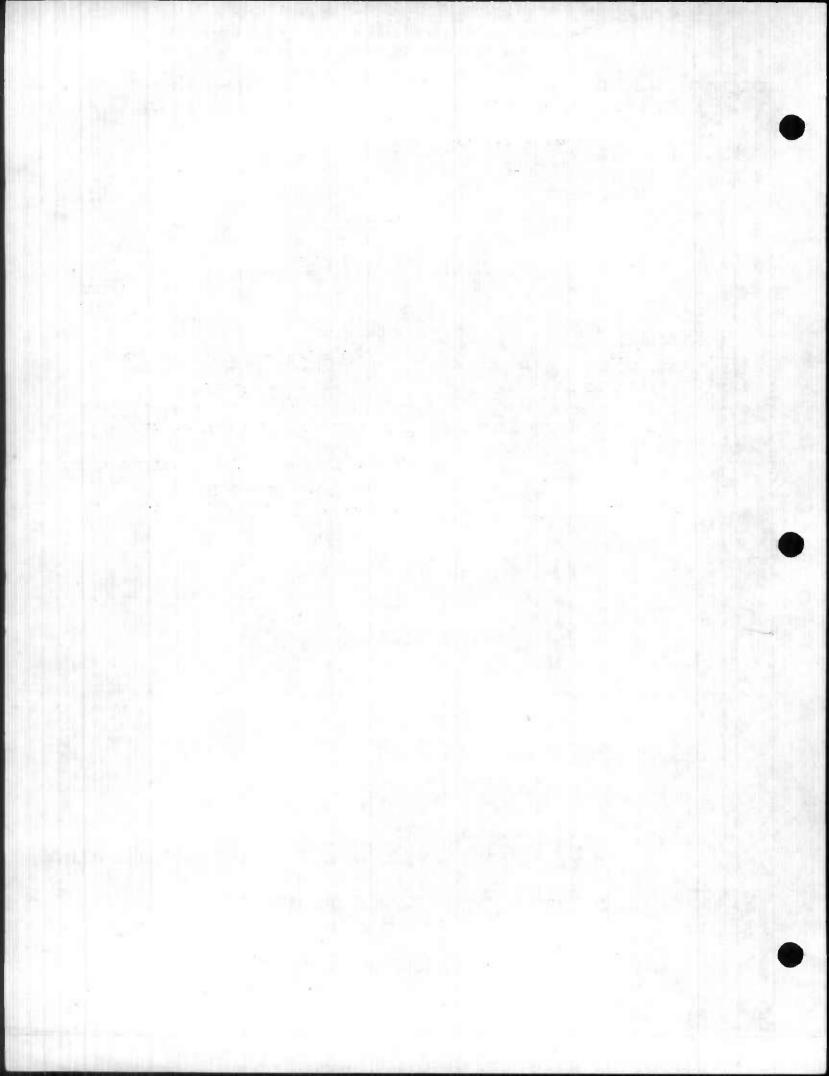
Due to (or es a consequence of)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of iviaryia		rtificate of			leg. No.	4201	68
		1. Decedent'a Name (First, Middle, Last)					2. Dete of Dea Month		Year 3.	Time of Death
	Physician /Medical	ETHEL, NEW	MAN		1500			R 30, 2		1:10 PM
	Examiner	4e Fecility Name (If not institution, give st	treet end number)			4b. City, Town, or L	ocation of Death	4c. County		
		UNIVERSITY OF MAR	4 LAND HOSF	PITAL		BALTIMOR			ore co	UNTY
	Funeral Director	5. Sociel Security Number 6. Sex 1 1 1	7. Age (In yr	rs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day JUNE 2,	Year) 1933		(State or Foreign VA
	Mand Mt	Usuel Residence of Decedent 10a. Stete 10b. County	10c. (City, Town or Lo	ocation		388			nside City Limits
	the Ma 28e-f s notified notified	MD NA		BAI	LTIMORE				1	☐ Yes 2 No
	or 28a-f s be notified Director	10e. Street and Number	THE STATE OF		10f. Zip Code		1	l 0g. Citizen of W	/hat Country?	
		1815 EAGLE STREE	ER		2	1215			IISA	
Maryland 21215-0036	urs after death of or thems 23 Examiner must by Funeral		2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	USA - American In k, White, etc. AFRICA AMERIC	N
2	ratur leaf	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	pation during most of work	ina	16b. Kind of Bu	siness/Industry	
2	ed within 72 ho ygiene. ser than "natur it, the Madical Completed	(Specify only highest grade Elementery/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	n iy			
2	Mary Con	12th	NA		HOME M				DUSE	
pu	Be Be	17. Father's Name (First, Middle, Last)				18. Mother's Nem	e (First, Middle,	Maiden Sumam	e)	
yla	Mem Mem	JOHN GIVENS				EHT	EL GIVE	NS		
lar	Tage of the stage	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Numbe	r, City or Town,	Stete, Zip Code	9)
- 65	and	EARLINE A. SILVE		3528	LUCILLE	AVE BALT		MD 2121		
Baltimore,	A Head	20a. Method of Disposition **Disposition 3 December 3		cemetery, cre	osition (Name of metory or other pla	ca)	Date	20c. Location -	City or Town, S	State
E	Page	4 □ Donetion 5 □ Other (Specify)		RBUTUS	MEMORIAL	PARK	1/5/01	BALTIN	ORE. M	D
a	mit.	21. Signeture of Funeral Service Licitore	7	2	2. Name and Addre		01/77 77			
m	80118	Mala			WYLLE	FUNERAL H	OME PA	AT MTMOT	, T V.D.	01017
	Physician /Medical Examiner	23a. Part1. Enter the disease, or comodic shock, or heert failure. List only one immediate Cause (Final disease or condition resulting in death)	BACTE	REMI	A	ng, such as cardiac	or respiratory an	rest,	App tnter Ons	21217 proximete rval Between set and Death
	<u> </u>		Due to	o (or as a conse	quence of):				1	
68760,	rificate be executed gophysician and as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last		o (or as a conse				Kak T	1	
Вох	death certification of for use a	d.								
	the atterned for hed f	Part II. Other significant conditions cont	ributing to death but not r	resulting in the u	inderlying cause gi	ven in Pert I.	23b. Did t	obacco uae cor	ntribute to the	cause of death?
P.0	that the de detached detached	CORONARY HEA	RT DISE	ASE			101	/es 2□ No	3 Probably	4 Unknown
Records	The law requires that the death cert site has been signed by the attending page 2 should be detached for use. Completed by Physician/M	DIABETES M	ELLITUS				24a. Was a perfor	an autopsy med?	evailabl	utopsy findings le prior to tion of cause h?
	The lew ete hes page 2	PERIPHERAL VA	SLULAR	DISE	ASE		1 U Y	es 2000	1 ☐ Ye	s 2 No
ita	certificate rector, pag	25. Wes case referred to medical				26. Place of Dee	th (Check only or	ne)	1	
>		examiner? 1 ☐ Yes 2 💢 No	ospital: Unpatient 2	☐ ER/Outpatie	nt 3 DOA Ot	her: 4 Nursing H	ome 5 ☐ Resid	lenca 6 Oth	er (Specify)	
Division of Vital	To the Hoppital or Attending Physical Physical Physical Physical Completely filled in by the funeral dompletely filled in by the funeral decompletely filled in the funeral filled in th	27. Menner of Death 1. Neturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury		ryat rk?]Yes 2 □ No	28d. Describe h	low injury occuri	ed	
Divis	The Hospital or Attending P A frought and the Carlo of th	3 Suicide 6 Could not be determined	28e. Plece of Injury - Al building, etc. (Spe	t home, ferm, st ecify)	reet, tactory, office		28f. Location (S City or Tow		er or Rurai Ro	ite Number,
	Funerilletely fill		cian: To the best of my ker: On the basis of examinend manner stated.							
		29b. Signature and title of certifier	10		29c. Licen:	se number	The End	29d. Date signe	d (Month, Dey,	Year)
	()	Vosema del	dur 1	40	60	0 1296		DECEMI	BER 3	0,2000
	9	30. Nama and address of person who con	npleted cause of death (II	tem 23a) (Type						
		ZZRNANDO A. LOPEZ				ET BALTI	MORE M	ARYLAN	UD 217	01
	State	31. Dete filed (Month, Day, Year)	32. Registrer's Sig						-12	
	Registrar	JAN Q 3 2001	Lingrama	· M	Ann. 11	,				

ORIGINAL



RONALD PULT.FP

State of Maryland / Department of Health and Mental Hygiene

artificiti of Ficaltif and	Montainguiche
rtificate of Death	Reg. No.

THEK
Physician
/Medical
Examiner

Ronald Dennis Puller

2. Date of Death Month Day Yeer
DECEMBER 28, 2000

8. Dete of Birth (Month, Dey, Year)

MAY 4, 1943

3. Time of Death 11;25P.M.

2069

Directo

Funeral

py

Completed

Be

Examiner

Physician/Medicai

by

Completed

Be

2

Certification:

edica

4e Facility Neme (If not institution, giva street end number) 1444 S.CHARLES STREET

1. Decedent's Name (First, Middle, Last)

4b. City, Town, or Location of Deeth BALTIMORE

4c. County of Deeth

Funeral Director

7 is marked other than "natural", or items 23a or 28a-f ahow treumstic event, the Medical Examinar must be notified at

the Meryler

death

filed within 72 hours efter

Hygiene.

permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 Is marked oftwenty Injury or other treumatic event pares.

Maryland 21215-0036

Baltimore,

Box 68760.

Records,

Division of Vital

HEmpital or Attending

Usual Residence of Decedent 10a. State 10b. County N/A

10c. City. Town or Location

 Birthplace (State or Foreign Country) Maryland

Maryland

5. Social Security Number

220-36-8116

6. Sex 1 M 2 F

10f. Zip Code

tf Under 1 Year | If Under 24 Hrs. Months Days Hours | Min.

Yas 2 No

10d. Inside City Limits

10e Street and Number

1444 S. Charles Street 11. Marital Status

12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:

21230 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Bleck, White, etc. Specify.

White

1 Never Married 2 Married 3 Widowed 4 Divorced

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 Yes 2 No Specify:

16b. Kind of Business/Industry

10g. Citizan of What Country?

USA

Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) College (1-4or 5+) Plumber

7. Age (In yrs. last birthday)

Baltimore

Plumbing 18 Mother's Nama (First Middle Maiden Sumeme)

Jerome Puller

4 Donation

Lorraine Lowman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

19a. Intormant's Name/Relationship (Type, Print)

20b. Place of Disposition (Name of cemetery, cremetory or other place)

1444 S. Charles Street Baltimore, MD 21230

Baltimore, MD

Ella May Puller/Wife 20e. Method of Disposition

Metro Crematory Inc.

20c. Location - City or Town, State Date

5 Other (Specify) 21. Signature of Funeral Service Lieutipe

1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State

22. Nama end Address of Fecility.
Cremation Society of MD, Inc.

brezorchik Edward A. 23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line.

299 Frederick Road Baltimore, Approximate Interval Between Onsat and Death

1-2-01

Physician /Medical Examiner

physicien and the burial-trensit certificate be executed

50 950 0

signed by the a

page 2 s certificate hes

the funeral director,

filled in by

After this

after death.

24 hours

To the

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

Immediate Cause (Final diseesa or condition resulting in death)

Arteriosclerotic Cardiovascular Disease Dua to (or as a consequence of):

Due to (or es a consequence of):

Due to (or as e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? INSPECTION

24b. Were autopsy tindings available prior to completion of ceuse of deeth?

1 ☐ Yes 2 No

26. Place of Death (Check only one)

1 Yes 2 No

25. Was cese retarred to medical Yes 2 No 27. Menner of Deeth

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Dey Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

111 Penn Street, Baltimore, Maryland 21201

29e. Certifier (Check only one

Netural 2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steted.

290. Signaldra and title of certifian

29c. License number

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rurel Route Number, City or Town, Stete)

O.C.M.E.

DECEMBER 29,2000

30. Neme and address of person who completed cause of death (Itam 23a) (Type, Print)

Hospital:

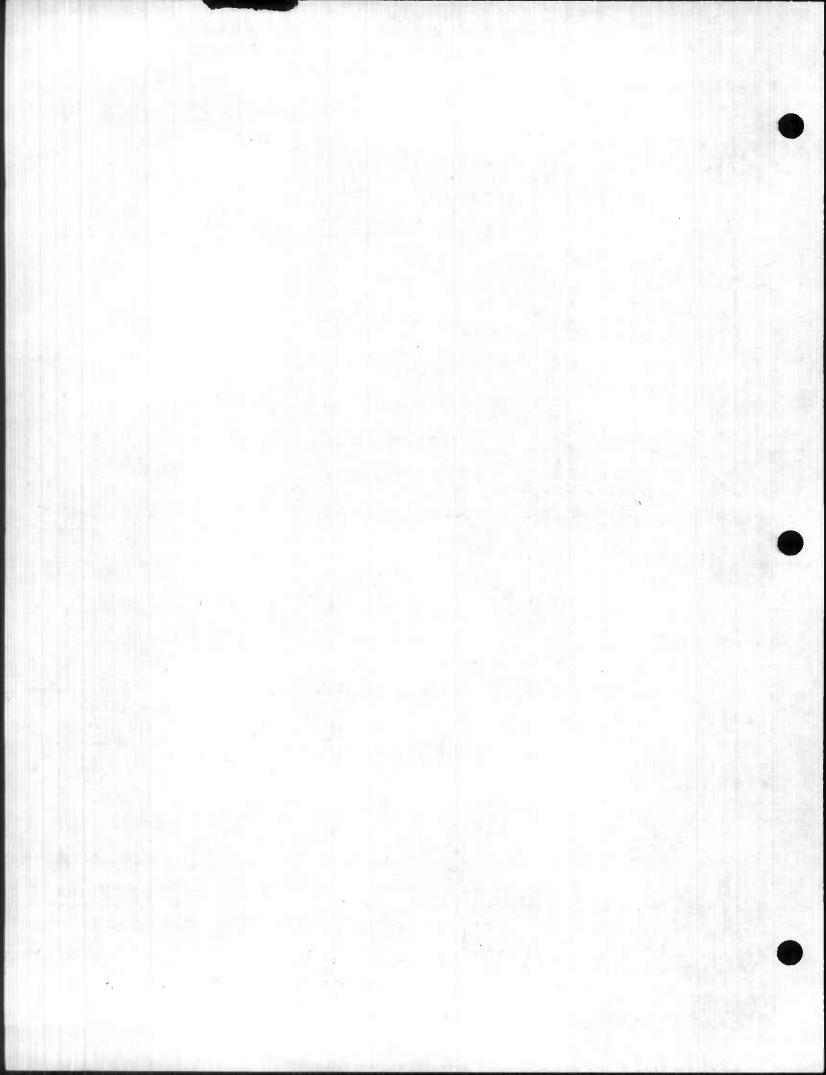
J. Laron Locke M.D. 31. Dete filed (Month, Dey, Year)

32. Registrar's Signature

Oaks

State Registrar

2. Eggs A Man

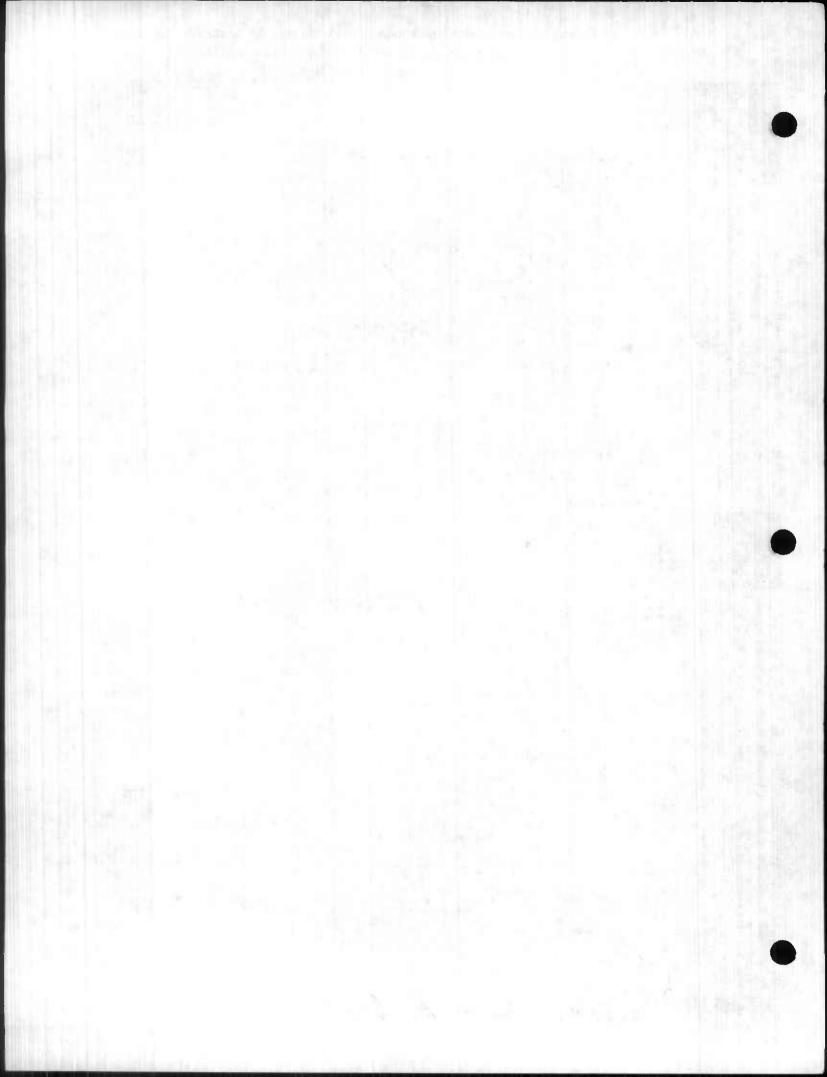


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 14207

			Certificate of	Death	Reg	g. No.	2010				
Dhusisian	Decedent's Nama (First, Middla, Last)				2. Date of Death Month	3. Time of Death					
Physician /Medical	Harry Walter Philli	ps			December	Day Yaar 2000	1735				
Examiner	4a Facility Name (If not institution, give street an		The Control	4b. City, Town, or Lo	cation of Death	4c. County of Death					
W 1 -	Anne Arundel Medica			Annapoli		Anne Arı					
Funeral Director	5. Social Security Number 222-01-5946 Usual Residence of Decedent	7. Age (In yrs. last birth	Months Days								
and w	10a. State 10b. County 10c. City, Town or Location 10d.										
vith the Mery	MD Queen Annes			1 □ Yes X⊠N							
eth with t	10e. Street and Number 101 Tennessee Road		g. Citizen of What Cou USA								
and 21215-0020 be filed within 72 hours after death with the Meryland tall Hygiene. d other than "natural", or Items 23s or 28s-1 show event, the Medical Exercition count be notified at Be Completed by Funeral Director	1XXNever Married 2 Married 1XXX	Decedent Ever in U.S. d Forcas? 'es 2 No s. Give or Dates: 1942-45	13. Was Decedent of If Yes, specify Cub		ecify Yes or No- Rican, atc.)	14. Race - Ameri Black, White Specify:					
21215-0 ed within 72 ho ygiene. er then "neturn ft, tre Medicinal Completed	15. Decedent's Education (Specify only highest grade comple	16e. [Decedent's Usual Occu Give kind of work done	pation during most of worki	ng 16	dustry					
Mple mple	Elementery/Secondery (0-12) Colle	ge (1-4or 5+)	Give kind of work done life. DO NOT use retire	ed)							
269.	12	W	elder	18. Mother's Name	(Final Adiates Ad	Railroad					
Maryland 212. d 2 should be filed within the and Mental Hygiene. T is marked other than traumatic event, the Mental traumatic event, the Mental Hygiene. To Be Compl	17. Father's Name (First, Middla, Last) Chester Phillips			Ethel U		aiden Sumame)					
Aaryla 2 should and Men is marke aumatic	19a. Informant's Name/Relationship (Type, Print)	19b. I	Mailing Address (Stree	t end Number or Rura	i Route Number,	City or Town, Stete, Zi	o Code)				
re, Maryla s 1 and 2 should f Health and Men frem 27 is marke other traumatic	Diane Emrick (Friend		1 Tennesse	e Road, St	evensvil	lle, MD 216	66				
0 80 = 5	20a. Method of Disposition XX Burlat 2 □ Cramation 3 □ Removal t 4 □ Donation 5 □ Other (Specify)	rom State cemetery	Disposition (Name of crematory or other plant to Memorial		01/04	20c. Location - City or Town, State Davidsonville, MD					
Baltim permit. Per Department Important: any lolury once.	21. Signature of Funeral Service Licensea	Home, P.A.									
	23a. Part1. Enter the disaase, or complications t shock, or heart failure. List only one cause	nat caused the death. Do no				olis, MD 21	.401 Approximate				
Physician /Medical Examiner particular parti	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury c	Die to (er as a co	ration	Phesm	07.9						
K 687 artificate ing phys e as the	Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of):										
der	Pert II. Other significant conditions contributing	to death but not resulting in t	the underlying ceuse g	iven in Part t.	23b. Did tob	sacco use contribute	to the cause of death?				
, P.O. Box that the death or ed by the shand detached for us / Physician/	Drosepsis				1 🗆 Yes	2 2 No 3□Pr	bably 4 Unknown				
of Vital Records, Physician: The law requires the confinate has been signarial director, page 2 should be a T to Be Completed by	Metastata	e Prost	ate Co	in cer	24a. Was an perform	ed?	Vere eutopsy findings veilable prior to ompletion of ceuse death?				
Vita clan: clan: actor. Be	25. Was case referred to medical examiner?			26. Plece of Deet	(Check only one)					
To To	1 Ves 2 No Hospital:		Datient 3LI DOA		me 5 Residen	nce 6 □Other (Spec	ify)				
VISION C Attending P or death. sctor: Atter i by the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation										
DIVISION (but or Attending P ts after death. at Director: Atten- and in by the furier Certification:		Place of Injury - At home, farmulding, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
hou hou	(Check only 2 Medical Examiner: On t	the best of my knowledge, ne besis of examination and/ manner stated.									
To the M within 24 To the Fi complete	29b. Signature and title of certifier		29c. Licen	se number	29	, Day, Year)					
	11. 11		05	518	+ 1	2/30/	2000				
2	30. Name and address of person who completed	cause of death (Item 23a) (T	ype, Print)	An	1	MO	21401				
State Registrar	31. Date filed (Month, Day, Year)	2. Registrar's Signature	Sporks	, , , , , ,	pol	3,,0	<i>L</i> \				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 791 1/3/2001 EW Certificate of Death

Ame	ended Item	#30	perDVRG79	1 1/3/2001	State of N	Marylan		artment e tificate			ind M	lental Hy	giene Reg. No	UU	46	2071	
		1. Decedent's Name (First, Middle, Last) In Donn Elia Pitilis							2. Dete of Deet Month					v ,	Yeer	3. Time of Deeth	
	Physician /Medical												00 8:00 P				
A^{-}	Examiner	40			re street and numbe		/ D		46	. City, Tov	wn, or Lo	ocation of Deet	tion of Deeth 4c. County of Death				
			Manor		ursing C			X T O D	Voar	Rux	tor			Balt			
ш	Funeral Director	3. 3		5-3432		73	last birthdey) Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da Apr.	y, Year	927	C y p	ace (Stete or Foreign ry)	
		Usu	al Residence of D									mpr	, -		OJP	1 45	
9	how		Md.	10b. County N / A			, Town or Lo								10	d. Inside City Limits	
7	octo																
5-0020	instruction with the meryes reserve the control of	10e. Street and Number 10f. Zip Cod 2 10f. Zip Cod 2								10g. Citizen of What 224 U.S.A.						ry?	
4	m 23	11	Merital Status		12. Was Decedent Ever in U.S. 13. Wes Decedent of Hispanic Ori							14. Race - American Indian,					
	Funer	1"	Mentar Status 1 ☐ Never Merried	Armed Forces? 1 ☐ Yes 2 ☑ No			If Yes, specify Cuban, Mexican, Puerto								tc.		
21215-0020	by F		3 ₩ Widowed 4	If Yes, Give Year or Detes	tf Yes, Give ¹ T 1 ☐ Yes 2 No Year or Detes:] No	Specify:				Specify: White				
5-0	ygiene. Northen "natural", It, me theorea En			5. Decedent's Ed			16e. Decedent's Usual Occupation (Give kind of work dona during most of work					in a	ustry				
121	then.	E	lemantary/Second		Cotlege (1-4o	r 5+)	life. L										
	Hygiene ther the		8th Father's Neme (Fi	irst Middle Last)	Owner/Operator						e (First Middle	ing				
an			Elia P							Dfı		Unknow					
Maryland	opinities in the state of the s		. Informant's Nem		Type, Pnint)		19b. Mailin	g Address (5	Street er			el Route Numb		or Town, S	tete, Zip (Gpdg)3 / O	
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0 -	of Healt f Rem 27 r other t	20a	Mathod of Dispo		Damen of from State	0	lace of Dispo	sition (Name	of			Dete	20c. L	ocation - C	ity or Tov	vn, State	
im	Department of Important: If he moortant: If he any injury or o		4 Donation 5		Removet from Stet y)	0	akLaw	n Cen	iete	ery	12	-27-00	Ba	lto.	, Md	•	
Balt	Depertment Important: I any Injury o	21.	Signeture of Fune	eral Service Lice	500		R 22	Name and	Address	of Fecility	n –M	atthew		Fune	ral	Home, In	
ш	66568		Edus	on K. 1	Erkin	N	21	34 Wi	111	ow S	pri	ng Rd.	. Ba			. 21222	
		234	. Pert1. Enter the shock, or heart	disease, or com failure. List only	plications thet cause one cause on each	ed the death line.	n. Do not ente	er the mode o	of dying,	, such as	cerdiac	or respiretory e	rrest,			Approximete Interval Between	
	hysician						0.0								1	Onset and Death	
	/Medical xaminer	dis	nediate Cause (Fi ease or condition ulting in death)	nat	θ	0	PD								16	>Mon 13	
	je je					Due to (o	r as e conseq	uence of):									
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39 3	Med T	resulting in death) Last															
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0 7	the a hed f	Part	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contributa to the cause of death?					
و ۵	detac											10	Yes :	≥□ No	3 Prob	ably 4 Unknown	
of Vital Records,	signe d be d											24a. Wes	an auto	osv	24b. We	re autopsy findings	
00	12 (7) 1000												ormed?		con	ileble prior to nptetion of ceuse leath?	
I Rec	ate has page 2											10	Vac 2	No		Yes 2 No	
tal fa	certificata rector, pag		Was case raferre	d to medical						26 Place	of Deat	h (Check only		140	11	1165 20140	
of Vita	nis certific I director.		axaminer?		Hospital: 1 ☐ Inpa	tient 2	ER/Outpatien	t 3D DOA	Othor			ome 5 Res		6 □Othai	(Specify)	
0 4	h. After this funaral d		Manner of Death	5 Pending	28a. Data of In (Month, E	jury ev Year)	28b. Tima of	280	. Injury Work	at ?		28d. Describe	d. Describe how injury occurred				
Vision	eath. ov: Af the fu		2 Accidant	investigetion	n			М	1 🗆 Y	es 2 🗆 1	No						
Division	at Director: After the funariant Certification:		3 ☐ Suicide 4 ☐ Homicide	determined	286. Place of I	28e. Place of Injury - At homa, term, street, factory, office building, atc. (Specify)					281. Location (Street end Number or Rural Route Number, City or Town, Stete)						
	C S B B B B B B B B B B B B B B B B B B		Contilled		-I-I T-M-1		1.1 1 1			4 4 4 4				\ · · · ·			
To the Hounital	within 24 hours after death. To the Funeral Director: After the empletely filled in by the funaral Medical Certification:	298	. Certifier 1, (Check only 2	☐ Medical Exar	ysician: To the bes niner: On the basis	of examinet	ion end/or inv	estigation, In	tna tima my opi	a, data en inion, daal	a pièce, Ih occur	end due to the red at tha time,	data an	d plece, er	ner as sta nd dua to	the ceuse(s)	
4	Me		. Signature end tit	le of certifier	1)/	7		29c. l	icense	number			29d. De	ete signed	(Month, L	Dey, Year)	
	5/			MI	100				04	54-	75		12	26	00		
	N	30.	Neme end eddres	s of person who	completed cause of	deeth (Item	23a) (Type.			- 1	1						
(15		Mohammad 1				ne Suit		Balt	imore.	Md 2	1237					
	Circle	31.	Dete fited (Month,			trar's Signe		435	del .	Phone .	*						

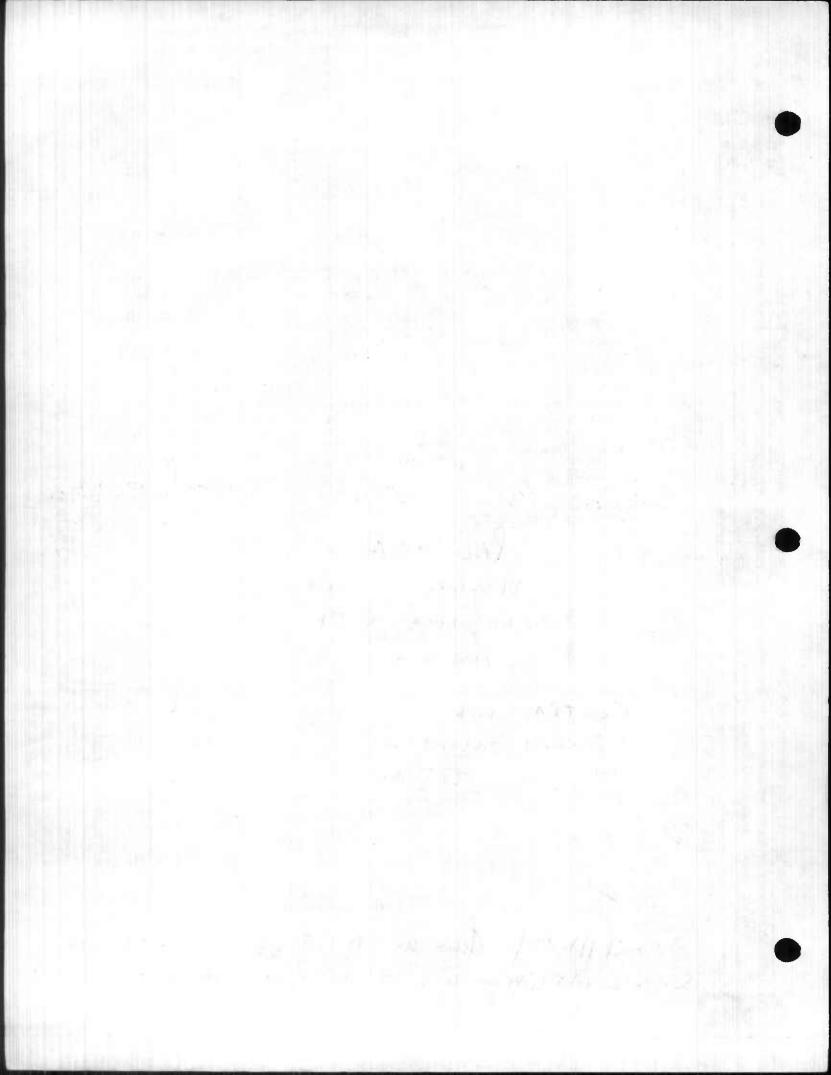
State Registrar

Sant Sa Fragal S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 42072

Directors Directors Control C				0.0.0	(Certificate		Death			eg. No.	1 2-4			
Friedrich Friedrich (1997) Fr		61	1. Decedent's Name (First, Mid							3. Time of D	Death				
## Facility Name of Protection Control			Yolanda	ritchet	t				2 - 28 - 2000		14:15				
Secolar Sciency Number Secolar Science of Department Number Secolar Science of Science of Department Number Secolar Science of Department Number Secolar Science of Scienc			4e Fecility Neme (If not institut	ion, give street and numbe	er)		1	**		of Death	4c. County	4c. County of Death			
Direction of Control o			7718 Gough Str	eet				Baltin	nore		N/A				
The control of the co			213-10-3126		V	Months Days Hours Min.					Year) 912	try)	Foreign		
Physician Physic	inyland show	show det	10a. Stete 10b. County 10c. City, Town or Location 10d. fns												
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The Security of the Security of the Security of the Security of Se	020	urs efter de al', or item Example: by Fune	1 Never Memied 2 M	Armed Forces	1 Yes 2 No If Yes, Give 1 Yes 2				Puerto Rican	es or No-	Specify:				
The Security of the Security of the Security of the Security of Se	0-0	2 ho	15. Deced	15. Decedent's Education			16a. Decedent's Usual Occupation				16b. Kind of Bu	siness/Inc	Justry		
The Security of the Security of the Security of the Security of Se	215	hin 7			(r.54)	(Give kind of work done during mo life. DO NOT use retired)			f working						
20. Memor of Disposition Charter of Controlling Charter of Charter of Controlling Charter of Charter of Controlling Charter of Charter of Controlling Charter of	21	d with					Seamstress				Text	ile			
20. Memor of Disposition Charter of Controlling Charter of Charter of Controlling Charter of Charter of Controlling Charter of Charter of Controlling Charter of	b	# T # 5 6	17. Fether's Neme (First, Middl	e, Last)				18. Mother's	Name (Firs	t, Middle, A	Maiden Surnam	(0)			
20. Metroo of Disposition The burst T	/a	Aente de	Pasquale F. A	moroso				Mar	ia Jo	sephi	ne Gioi	a			
20. Metroo of Disposition The burst T	an	S D E E	19e. Informent's Neme/Reletio	nship (Type, Print)		19b. Mailing Address (Street and Number or Run					, City or Town,	State, Zip	Code)		
Committee Comm	Z	D 5 1 5	Donald Kuessne	r Son	77	18 Gough	n SI	Balt	imore	, MD	21224				
Physician Medical Examiner 23a Pert. Einer the disease, or complications had easily to not enter the mode of dying, such as cardiac or respiratory arrest, interned Between Cheek and Death (The as a consequence of): 25a Pert. Einer the disease, or complications had easily to the cause of pertine the complete of the complete of the cause of	more	ant of He nt: If item y or oth	1 D Burial 2 Cremetion		te cemetery	, cremetory or oth	ner plac						wn, Stete		
Physician Medical Examiner 23a Pert. Einer the disease, or complications had easily to not enter the mode of dying, such as cardiac or respiratory arrest, interned Between Cheek and Death (The as a consequence of): 25a Pert. Einer the disease, or complications had easily to the cause of pertine the complete of the complete of the cause of		orten Injur			Darco-W	22. Name and	Addre	ss of Fecility	-						
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Immediate Cause (Fine) disease or condition disease or conditi			23a. Perf1. Enter the disease, shock, or heart failure. L	or complications that caus ist only one cause on each	ed the death. Do no line.	ot enter the mode	of dyin	g, such as ca	rdiac or resp	oiratory erro	est,		Interval Between	een	
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State 31. Date filed (Month, Dey, Year) 32. Registrar's Signature	1	JY	30. Neme and eddress of person	m who completed dause of	death (Item 23a) (T	ype, Print)	1							37	
Registrar JAN 0 3 2001 Departs	I		31. Date filed (Month, Dey, Yes	17) 32. Regis	/	B	10:			.0				,	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Yeer QUARLES **Physician** 8:25 a.m CHARLES December 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Harbor Hospital Center n/a 7. Age (In yrs. last birthdey) 90 Yrs. If Undar 24 Hrs. 5. Social Security Number Birthpleca (Stata or Foraign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** Deys 1⊠M 2□ F Months Hours 215-05-0347 Director Sept.29 1910 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mantal Hygiene Tratural, or thems 23a or 28a-f ahor snyling or other traumatic avant, the Madest Examine must be notified at page. Md. n/a 1 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3612 Third Street 21225 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No. If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours efter 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Purchasing Agent CM Kemp 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Hudson Hubbard Gertrude Quarles 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 3612 Third Street, Baltimore, Md. 21225 (Wife) Margaret C. Quarles 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation 3 Ramovel from State 4 Donetion 5 Other (Specify) Baltimore, Md. Cedar Hill Cemetery 01/04/2001 21. Signature of Funerel Service License 22 Nama and Address of Fecility McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, MD. me 21225 23a. Part 1. Entar tha disaasa, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, mock, or heart failure. List only one cevise on eech line. Approximate Interval Between Onset end Death Physician Respiratory Di Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner and Lung Collapse The lew requires that the death certificate be executed Sequentielly list conditions, if any, leading to immadiate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest ettending physiclan and Lung Cancer
Out to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Atrio ventricular Block 23h. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa givan in Pert I. 1 Ves 2□ No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 25. Wes cese referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☑Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 eral Diractor: After this rilled in by the funeral dir 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 1 2 Naturel Certification: 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signatura and titla of certifier ibaly Res 001 December, 31,2000 30. Nema and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Kourosh Dibadj, 3001 South Hanover Street, Baltimore, Maryland 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

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Sports **ORIGINAL**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 31, 2000 4c. County of Death Mary Virginia Ritter December 10:00 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Paradise Assisted Living Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 23, 19 Birthplace (State or Foreign Country) 1 M 2 XF Months Days Hours Min Yrs. 75 21.8-18-6654 Usual Residence of Decedent Maryland 10a State 10h County 10c. City. Town or Location 10d. fnside City Limits Maryland Baltimore Catonsville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6348 Frederick Road 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Sales Associate J.C. Penny Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK. Cooke Hilda UNK. 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Lippy/Daughter 114 Heritage Lane Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-2-01 Metro Crematory Inc. Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee Thomas Gregor 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate fntervel Between Onset and Death Immediate Cause (Final disease or condition resulting In deeth) Due to (or as a consequenca of): SM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence d() that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living examiner? Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death fnjury at Work? Natural 5 Pending investigation 1 Yes 2 No 2 Accident

Physician/Medical Examiner attending physician end for use es the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the aid be detached to has t After this certificate har funeral director, page Hospital or Attending Physicien: 24 hours after death. Funeral Director: Witnesse Ho

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Health and Meniel Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Empires must be notified at once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

by Be Completed 2 Certification: edical

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b, Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

6 Could not be determined



Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 22472

Decritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29d. Date signed (Month, Day, Year) 1-2-01

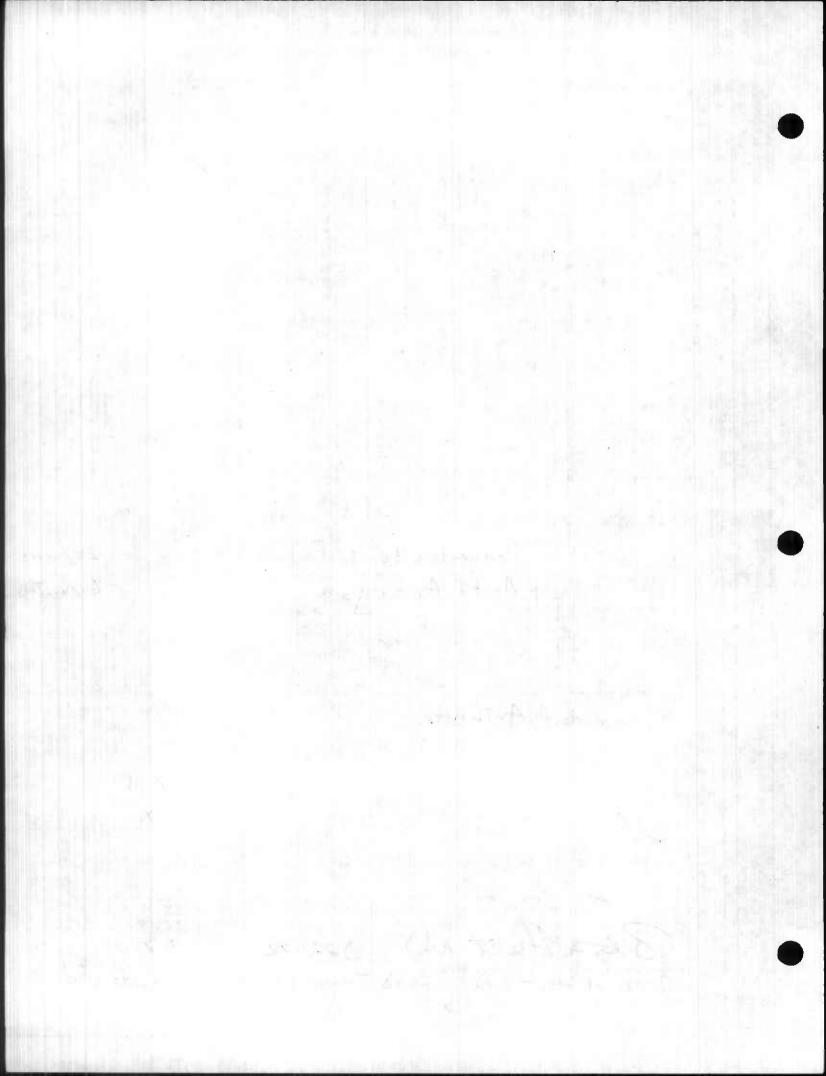
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

6000 Samaritan Hosp

32. Registrar's Signature

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 30 2000 Physician JULIA Α. RUSSELL DEC. 10:50pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 200 HOPKINS LANE OWINGS MILLS BALTIMORE If Undar 24 Hrs. If Under 1 Yaar 5. Social Security Number 7. Aga (In vrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2⊠F Hours 245-36-4469 Director 04/09/1925 NORTH CAROLIN Usual Rasidance of Decedan the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f show Examine must be notified at 1 Yas 2 No Directo OWINGS MILLS BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 200 HOPKINS LANE USA 21117 death Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yaa or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. 11. Marital Status Black, Whita, atc. e filed within 72 hours efter of Hygiene. 1 ☐ Nevar Married 2 Married 1 Yas 2 No Specify Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed The Medical 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) Elemantary/Secondary (0-12) Collega (1-4or 5+) 2yrs HOUSEWIFE HOMEMAKER permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If frem 27 is marked othe any Injury or other treumatic event, page. 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First Middle Last) ARTHUR CHASE AMBLER MARY BARBER 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant'a Name/Ralationship (Type, Print) ALEXANDER H RUSSELL (HUSBAND) 200 HOPKINS LN. OWINGS MILLS, MD. 21117. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) THOMAS CEMETERY 01/03/2001 OWINGS MILLS, MD 21. Signatura of Funaral Sarvice Licensas 22. Nama and Addrass of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Dua to (or as a consequence of):
PLEWAL EFFUSION Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Examine certificate be syscuted physician end s the burial-trans Dua to (or as a consequence of): Sequantially list conditiona, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or injury that initiated evants CHRONIC UBSTRUCTIVE LUNG DISEASE Physician/Medical Dua to (or as a consequance of): rasulting in daath) Last attending ph signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco-use contributs to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown g 24b. Wara autopsy findings in a lable prior to the pletion of cause of death? should t Completed 24a. Was an autopsy performed? page 2 s 1 Tyas 2 The 1 Yas 2 No certificate Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ong) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 2 After this 27. Manner of Death 1 (2) Natural 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of Certification: 28c. Injury at Work? 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

Hospital or Attending death. Director: / efter

Division of Vital Records. P.O. To the Hospital within 24 hours of To the Funeral Completely filled

edical

12 State Registrar

PHILLIP BEUSCHER M.D. 31. Data filed (Month, Day, Year) JAN 0 3 2001

29b. Signatura and titla of certifiar

4 T Homicida

29a, Cartifiar

UNION MEMORIAL HOSPITAL BALTO., MD. 32. Registrar's Signature

and mannar stated.

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

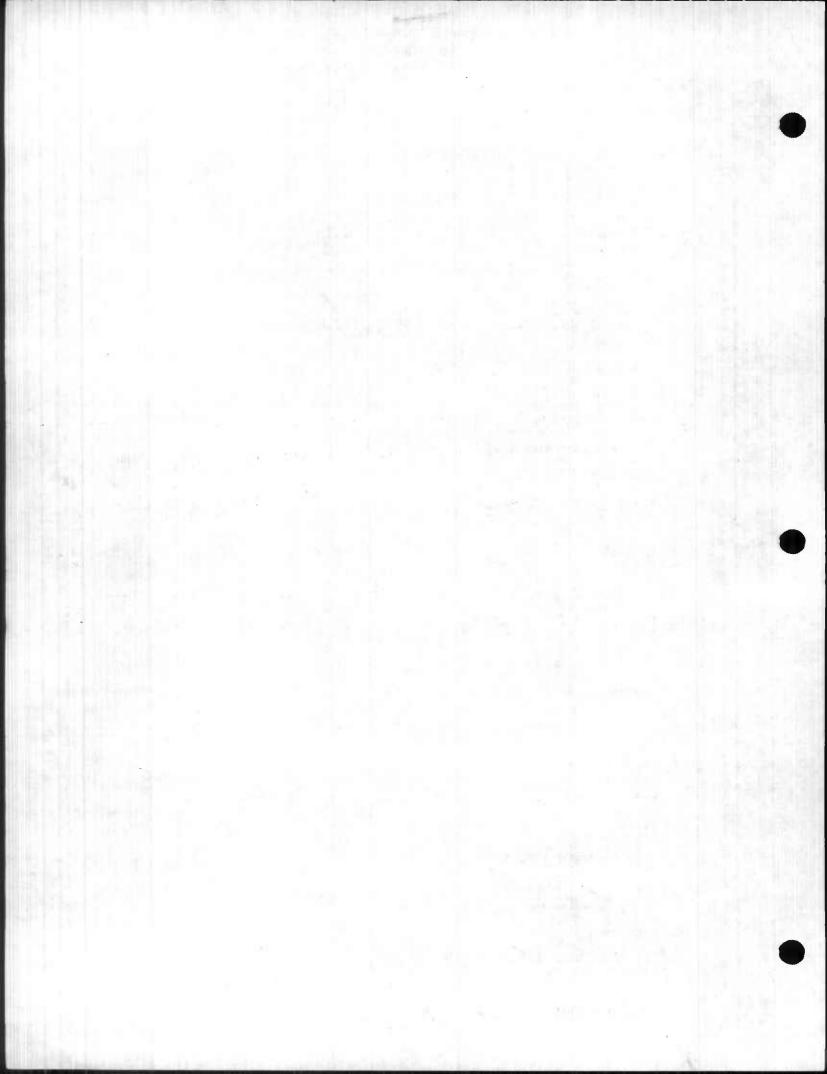
29c. Licansa number

29d. Data signed (Month, Day, Year)

21218.

2001

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 26, 2000 **Physician** LOUIS REDLER 12:25AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year 9. Birthplace (State or Foreign Country) 6. Sex 1∆ M 2 F If Undar 24 Hrs 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours AUSTRIA 95 213-03-2212 Director Usual Residence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits I be filed within 72 hours after deeth with the Manylen of other than "natural", or frems 23a or 28a-f show event, the Marice Emminer man by motified 1 Yes 2 No Director BALTIMORE MD BALTIMORE 10g Chizen of What Country? 10e. Street and Number 10f. Zip Code 21208 U.S.A. 4204 OLD MILFORD MILL ROAD Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Giva Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yas, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yas 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOVERNMENT CLASSIFIED 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be file Depertment of Heelth and Mantal Hy Important: if Item 27 is marked oth any Injury or other traumatic event Rota. 17. Father's Nama (First, Middle, Last) Be WHITMAN REDLER **EDITH** 2 MORRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intermant's Name/Relationship (Type, Print) 11203 WOODLAND DRIVE - LUTHERVILLE, MD 21093 BETTY COOPER / DAUGHTER 20a. Method of Disposition

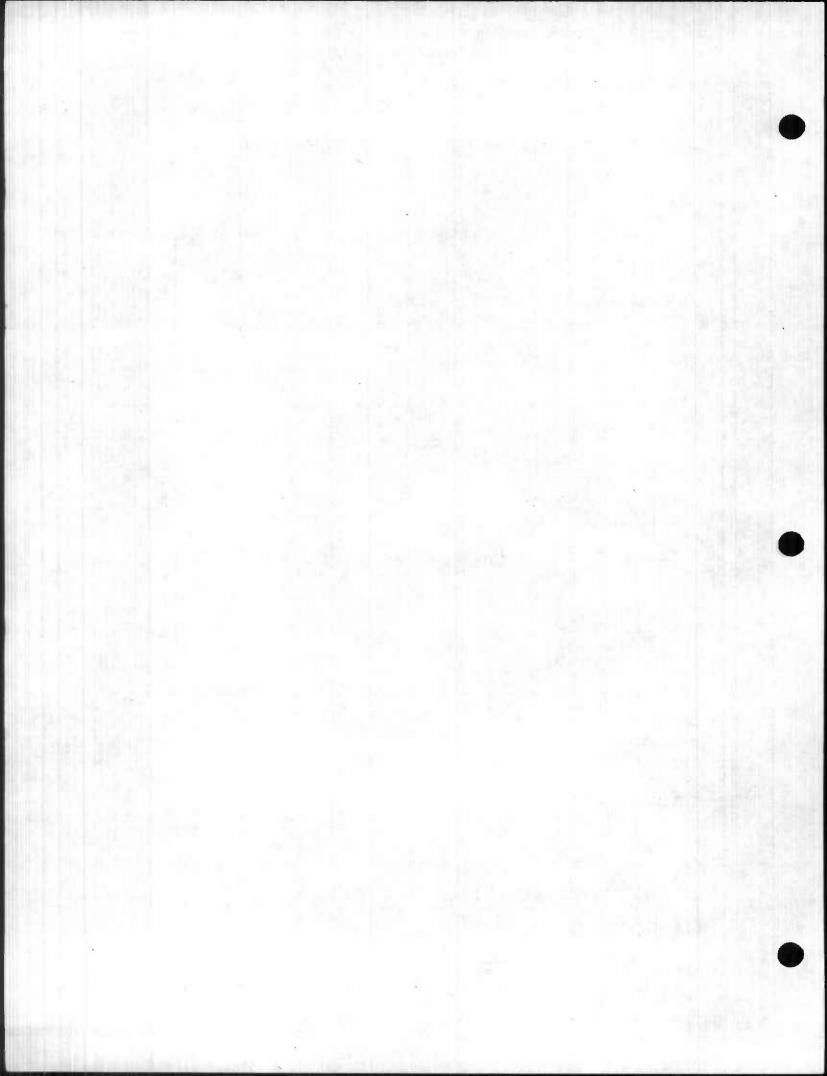
14 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) TAMID) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) LUBAWITZ NUSACH ARI (NER 12/31/00 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS. ROAD - PIKESVILLE, MD 21208 8900 REISTERSTOWN Approximate Interval Between Onset and Death fions that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, 23s Part **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) neumones Examiner Due to (or as a consequence of): Physician/Medical Examiner lew requires that the death certificate be executed ed by the attending physician end detached for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence ot): Due to (or as a consequance of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed by a page 2 should be detacl 1 Yes 2 No 3 Probably 4 Unknown helmen Division of Vital Records. þ 24b. Ware autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed this certificate has The 1 Yes 2 No 1 ☐ Yes 2 ☐ No spital or Attending Physician: Theoris after death.

nerel Director: After this certificate y filled in by the funeral director, pa 25. Was case reterred to medical Be 26. Place of Death (Check only one) axaminer? To Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 DNatural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 290. Signature en title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2000 who completed causa of daath (Itam 23a) (Type, Print) Reenterdown M621136 Mai 08 25 31. Data filed (Month) 32. Registrar's Signature Menara. Registrar

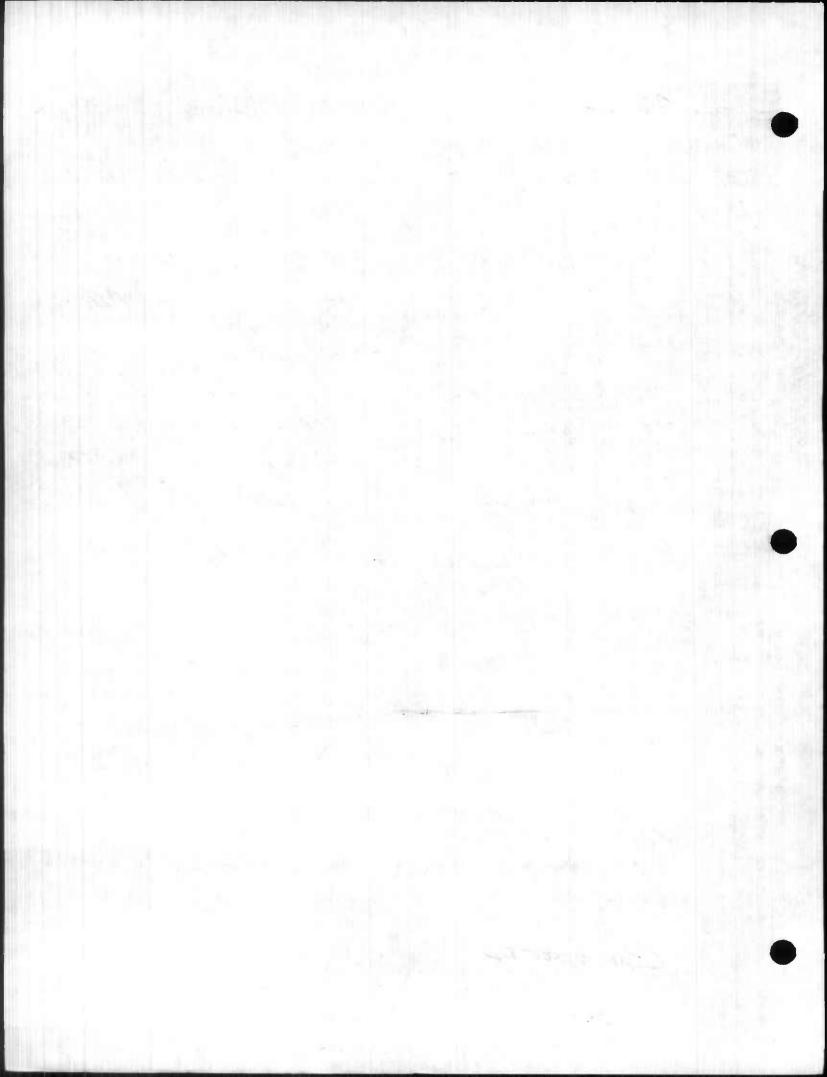
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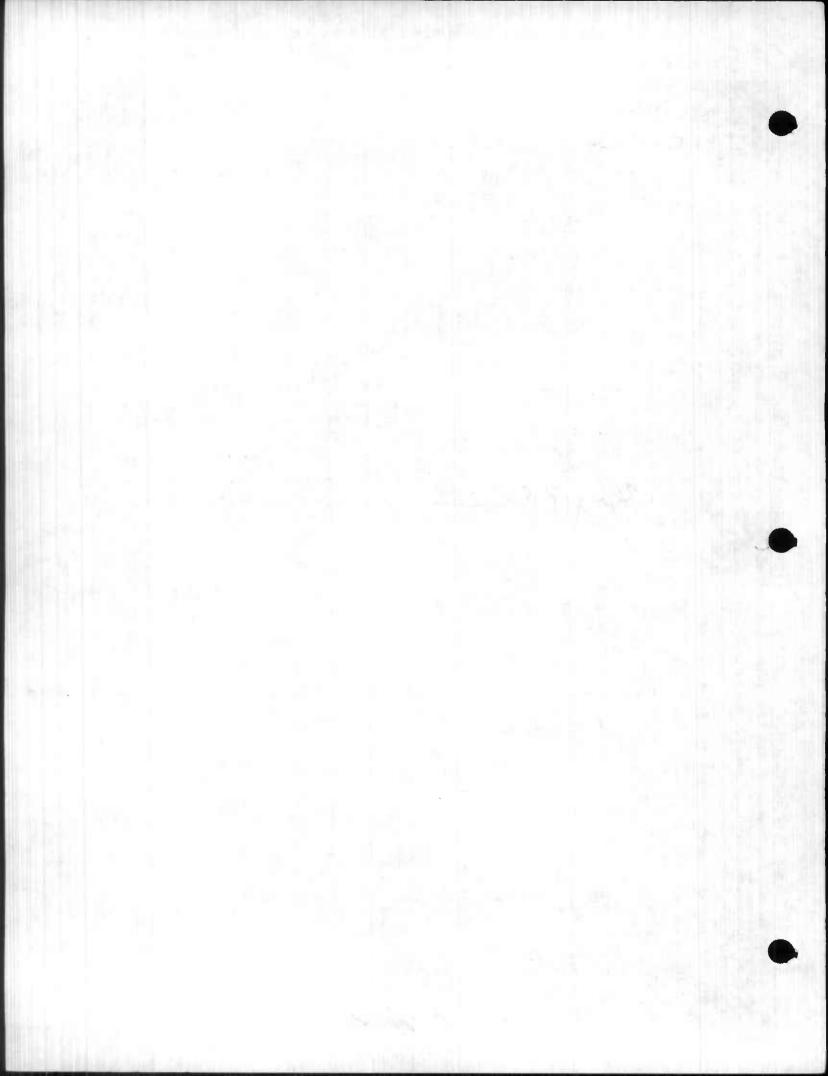
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 35 pm DILLIAM 25 2000 December /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bultinore Baltimore V. A. Medical altimore enter If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs. Birthplece (State or Foreign Country) 6 Sax 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Hours Min 1₽₩ 2□F Yrs 213-28-5328
Usual Residence of Decedent 73 Director MD Aug the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nd 2 should be filed within 72 hours after deeth with the Marylan ith and Mentel Hygiene. Pi land the state of the state o 1 ☐ Yes 201No Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Gwynnbrook Ave. 21117 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 N Yes 2 No 1945-II ¥es, Give Year or Dates: 1947 1 ☐ Never Merried 2 ☐ Merried 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 ☐ Widowed 4 ☑ Divorced 1947 Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Welder construction 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 To Thomas W. Seward Alice Baublitz 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum ans. 3867 Bull Run Creek Rd, Franklinville, NC 27248 Diane L. Schlein 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Serv. 1/2/2001 Hampstead, MD 22. Name and Address of Fecility 11824 Reisterstown Rd 4 Reisterstown, MD 21136 Eline Funeral Home or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ist only one cause on each line. Approximete fnterval Between Onset end Death 23a, Part1, Enl **Physician** 7Medical Immediete Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca of) Physician/Medical Examiner NOS sicien end buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) been signed by the attending physicien should be detached for use as the burie Box 68760 Due to (or as a consequence of) Division of Vital Records. P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were eutopsy findings eveilable prior to completion of cause of death? page 2 should Completed hes 2 No 1 Yes certificate Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 12 Inpetient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred il or Attending P 1 ☑ Netural 2 ☐ Accident 5 Pending Investigation 1 Yes 2 No Diractor: To the Hospital or Atter within 24 hours effer de To the Funeral Diracto completely filled in by th 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OW pecember 29,2000 1314 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 10 North Greene St Baltimore Sunners Baltimore VAMC Stephen an 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State JAN 03 2001 Registrar



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State Registrar

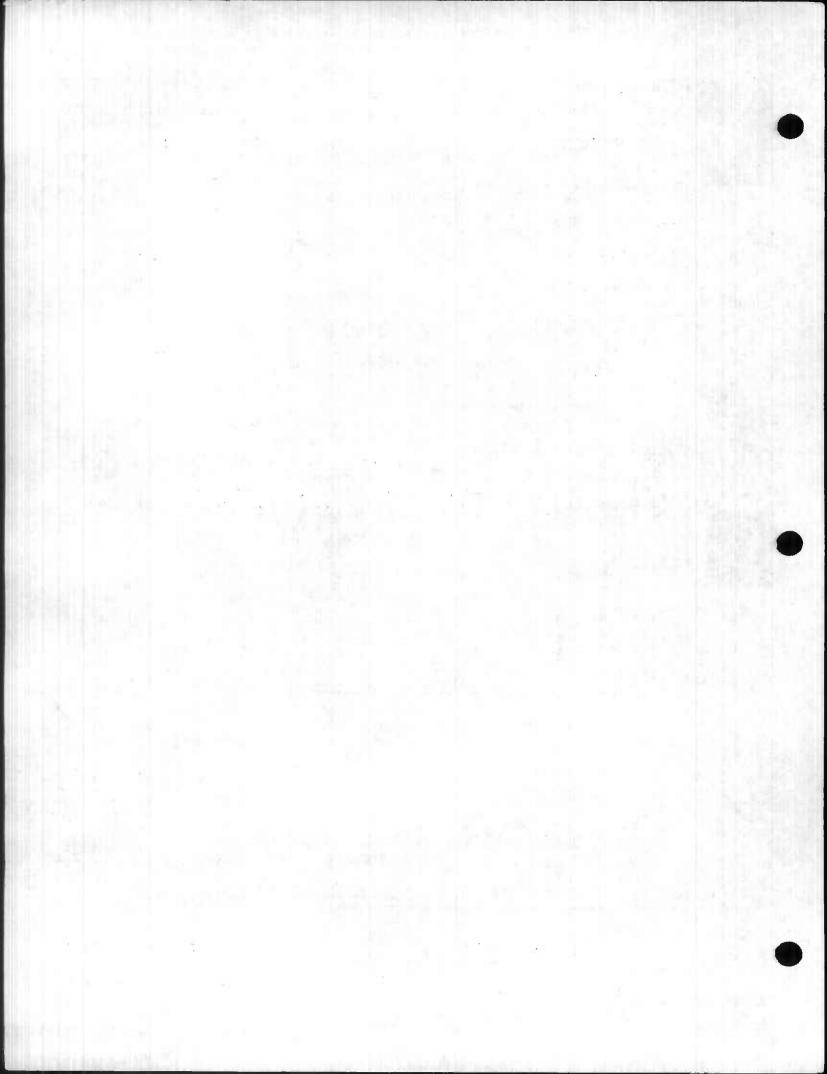
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JAN 0 3 2001

Security G. Spark

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#20b perFHG791 1/3/2001 EW Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death enthac 370W 27,2000 ccomb 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, give street and number) 4c. County of Death N/A Cc 1+c Merey Midi BALTIMORE If Under 1 Year | If Undar 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1 M 2 F Yrs. 215-18-6590 92 1/7/08 MD. Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ELLIOTT USA 21224 3126 STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forcas? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: WHITE 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOME 4 0 HOMEMAKER 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) BENJAMIN unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3126 ELLIOTT ST. BALTO., MISS CHERYLE SZULCZEWSKI MD. Date 2001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State SACRED HEART OF JESUS1/2/00 DUNDALK, MD. 4 ☐ Donation 5 ☐ Other (Specify)

Physician /Medical Examiner

The law requires that the death certificate be assecuted

Box 68760,

P.0.

Division of Vital Records,

To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical

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signed by

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filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mentel Int. If Item 27 is marked or

permit. Pages 1 and 2: Depertment of Health as Important: if Item 27 Is any Injury or other traughts.

Baltimore, Maryland 21215-0020

Physician/Medical Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

29b. Signature and Vie of certifier

31. Date filed (Month, Day,

Immediate Causa (Final disaasa or condition resulting in deeth)

23a. Part1. Enter the disease, or complica shock, or haart failura. List only ona

any

30. Name and address of person who completed cause of dath (Item 23a) (Type, Print)

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32 Registrar's Sig

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Due to (or as a consequenca of):	
Dua to (or as a consequence of):	

22. Name and Address of Facility KACZORWOSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTO., MD. 21224

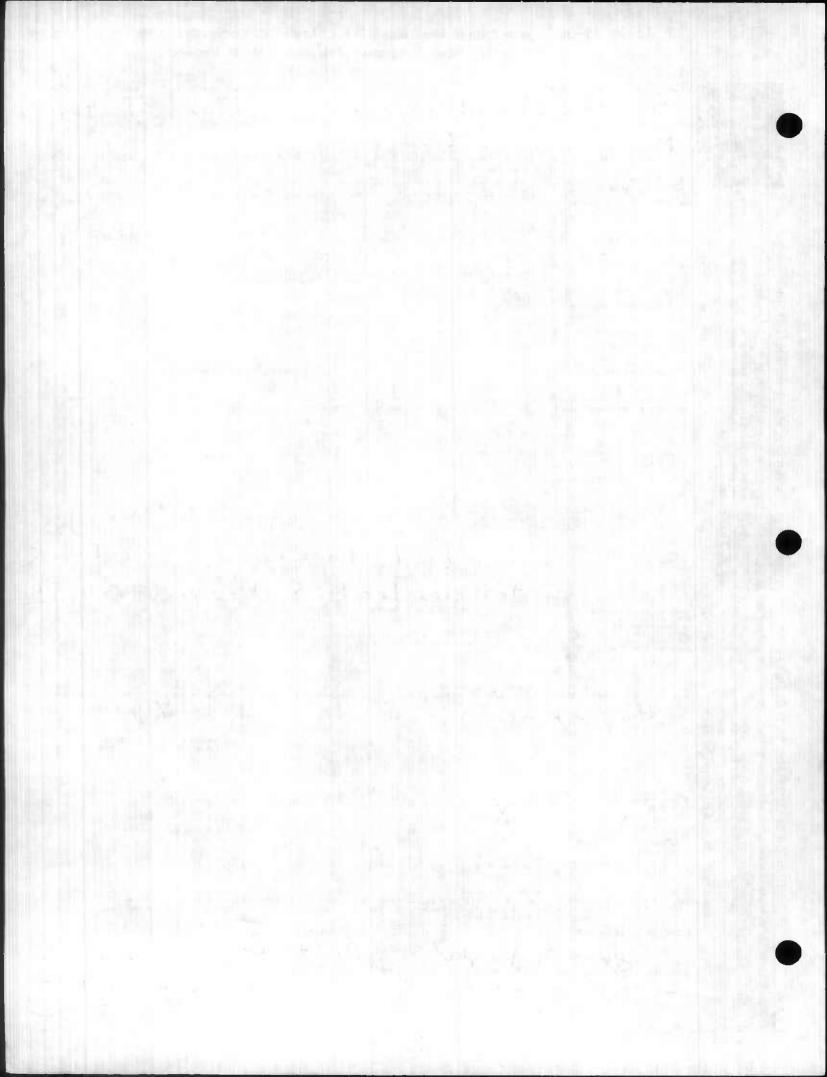
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy Be Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury et Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29e. Certifier (Check only one)

29c. License number

01

State Registrar



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Dete of Death 3. Time of Death 12 Dey 21 Yea Helen Skotarski 00 5:15 PM 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Canton Harbor Nursing Home Baltimore N/A If Undar 24 Hrs. 8. Date of Birth Month, Dey, Year 04-09-1911 If Undar 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. lest birthday) Min. Deys Hours 219-38-6882 1□M 20 F Months 89 MD Usuel Residence of Decedent 10e. Sfata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1209 Delbert Avenue 21222 USA Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, 12. Was Dacedenf Evar in U,S. Armed Forcas? 11. Marifal Status Black, White, etc. 1 Yes 2 No If Yes, Give A Yaar or Detas: 1 Nevar Merried 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: Caucasian 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker **Home** 3 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middla, Last) Felix Pruchniewski Antonia Karasinka 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Mrs. Frances Andryszak 1209 Delbert Avenue, Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removel from State Oak Lawn Cemetery 12/26/00 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Kaczorowski Funeral Home, P.A. 23a. Pert1. Enter the disease, or complication to trace death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately 1.201 Drundalk Avenue, Baltimore, Mary and 21222 Approximately 1.201 Drundalk Avenue, Baltimore, Mary and Drundalk Avenue, Baltimore, Balt Intervel Between Onset end Death Immediate Ceuse (Finel diseese or condition resulting In deeth) 14 DAYS MALMUTRITION Due to (or es e consequence of) DEMENTIA Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or as a consequence of): Dua fo (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown SEIZURE PISORDER 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

by

Completed

Funeral

Director

7 is marked other than "natural", or itams 23s or 28s-f show traumatic event, the Medical Examinations to notified at

the Marylend

death

72 hours after

Hygiene.

permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy important: If flam 27 is marked other any Injury or other traumatic event Dibles.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner attending physician and for use as the burial-transit signed by the a þ Completed peeu page 2 s has 86 10

certificate this

Division of Vital Records, P.O. Box 68760, Physician: i or Attanding F the Hospital within 24 hours a 0

DHMH 16 Rev 6/95

The law requires that the death certificate be executed Diractor: After this in by the funeral

Certification:

edicai

State Registrar

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) HARIS ALEEM 9101 FRANKLIM

MO

31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

25. Wes case raferred to medical exeminer?

1□ Yes 2□ No

27. Manner of Beath

1 Naturel

2 Accident 3 Suicide

4 | Homicide

(Check only one)

29e. Certifier

2001 3 JAN

5 Pending investigation

6 Could nof be

32. Regisfrer's Signeture

Hospifal: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28e. Dete of Injury (Month, Dey Year)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated.

29c. License number

1 Yes 2 No

29d. Dete signed (Month, Dev. Year) 2001

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Yas 2 No

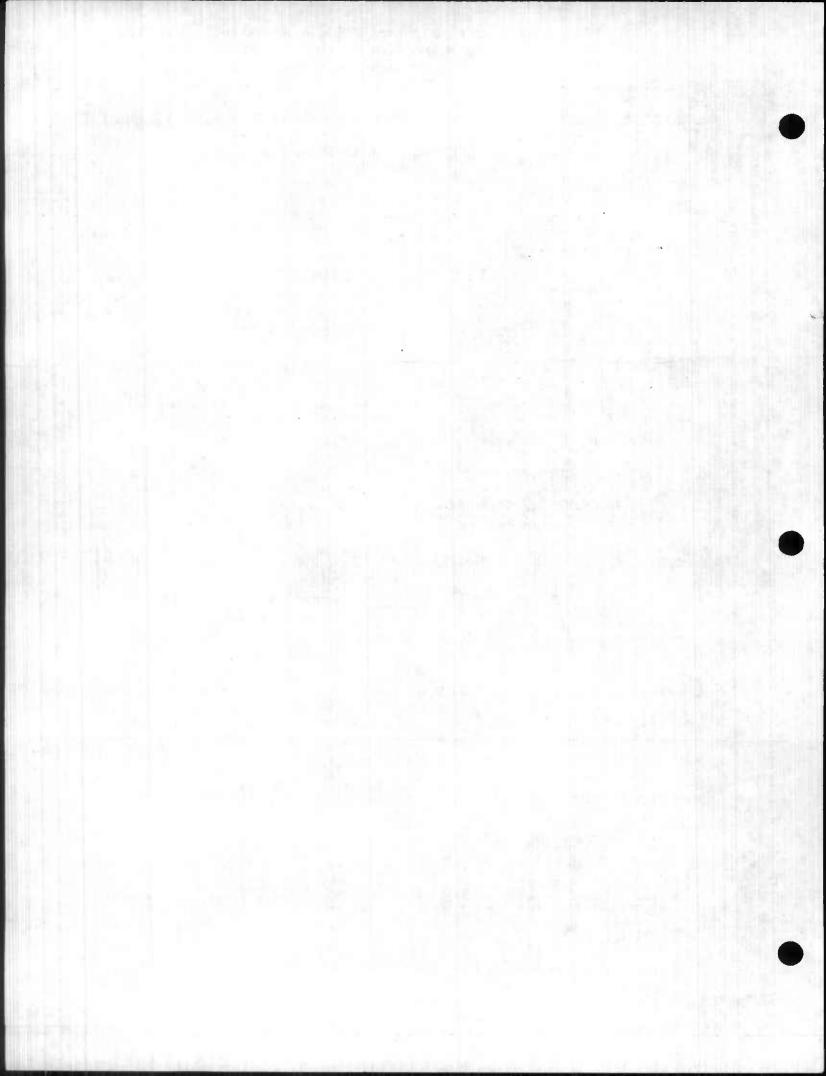
1 Yes 2 No

28d. Dascribe how injury occurred

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

SQUARE DRIVE BACTIMORE MD 71237



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Day 30 Month Year **Physician** 17:07 -hARC December 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore City Hopkins Johns Hospital If Under 24 Hrs. 8. Date of Birth Hours Min. Jan. 27, 1941 If Under 1 Year 5. Sociel Security Number 7. Aga (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** Deys Months Country) Md 1XM 20 F 59 Yrs. 218-36-4685 Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits pemit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23s or 28s-f show shi figury or other traumatic avant, the Medical Error nest the notified at page. 10a. Stata 10b. County 1 ☐ Yes 2 No Directo Md. Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2644 Masseth Ave 21219 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ⊇No If Yas, Give Yaar or Detas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) Elementery/Secondary (0-12) 12 VIS College (1-4or 5+) Owner Tavern yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nema (First, Middla, Last) Joseph J. Staszak Sr. Helen Krawczykowski 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Catherine Staszak wife 2644 Masseth Ave. Edgemere, Md. 21219 20b. Place of Disposition (Neme of cametery, crematory or other piece) 20c. Location - City or Town, Steta 20a. Method of Disposition Jan.3, 1 ■ Burial 2 □ Crametion 3 □ Ramoval from Steta Sacred Heart of Jesus 4 ☐ Donetion 5 ☐ Other (Specify) Dundalk, Md. 22. Name and Address of Fecility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222 23a. Pertf. Enter the disease, or complications that caused the daath. Do tot enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Sepsis Examiner Physician/Medical Examiner arengeal Carcinoma ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Dua to (or as e consequenca of) Division of Vital Records, P.O. Box 68760 Dua to (or es a consequance of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 XNo 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? certificate has been si rector, page 2 should 24e. Wes en autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Physician: 25. Wes case referred to medical axaminar? 8 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No iours after death. Nersi Director: After this confilled in by the funeral dire To 27. Menner of Deeth 1 Neturel 2 Accident 28a. Deta of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury et Work? i or Attending Fatter death. 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral Dicompletely filled it 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) end manner steted. 29a. Certifier edical 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 14288

State

Registra

Valle Wolf Ledy. 500 Street 31. Dete filed (Month, Dey, Year) 32. Ragistrer's Signetura genera

30. Name and address of person who completed causa of death (Item 23e) (Type, Print)

Chalia

Baltimore City oanks

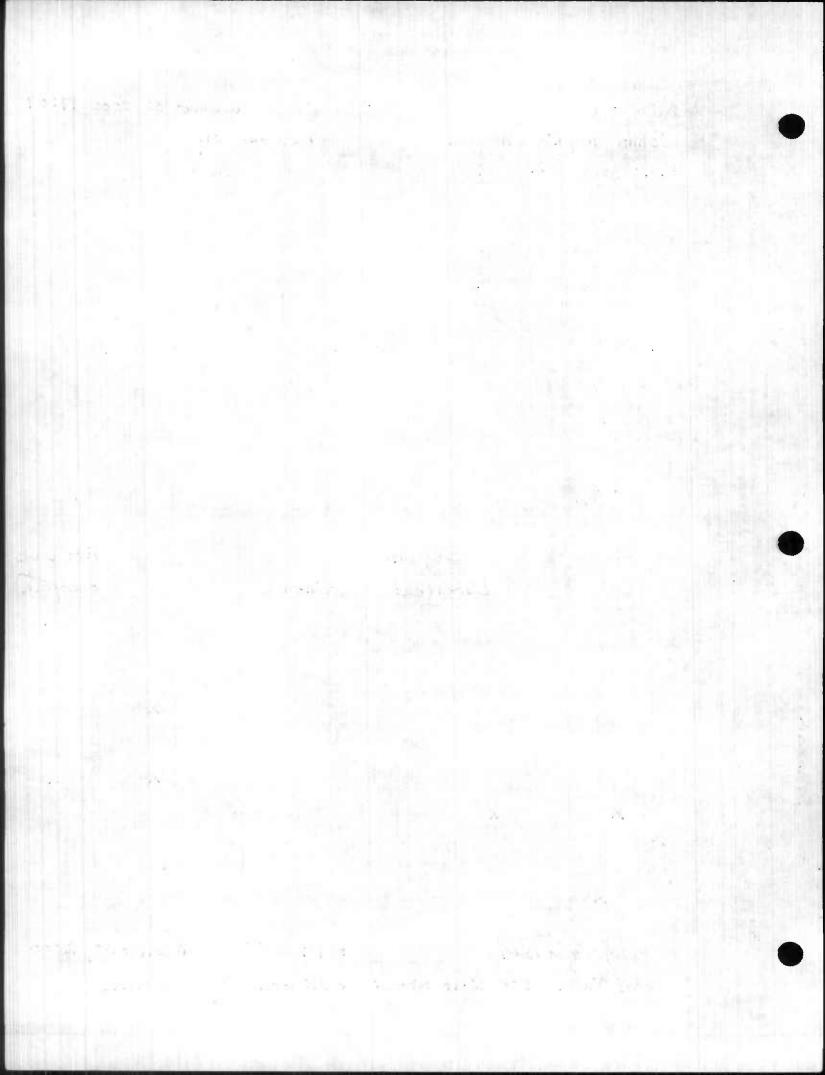
December 30, 2000

Maryland

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Staszak

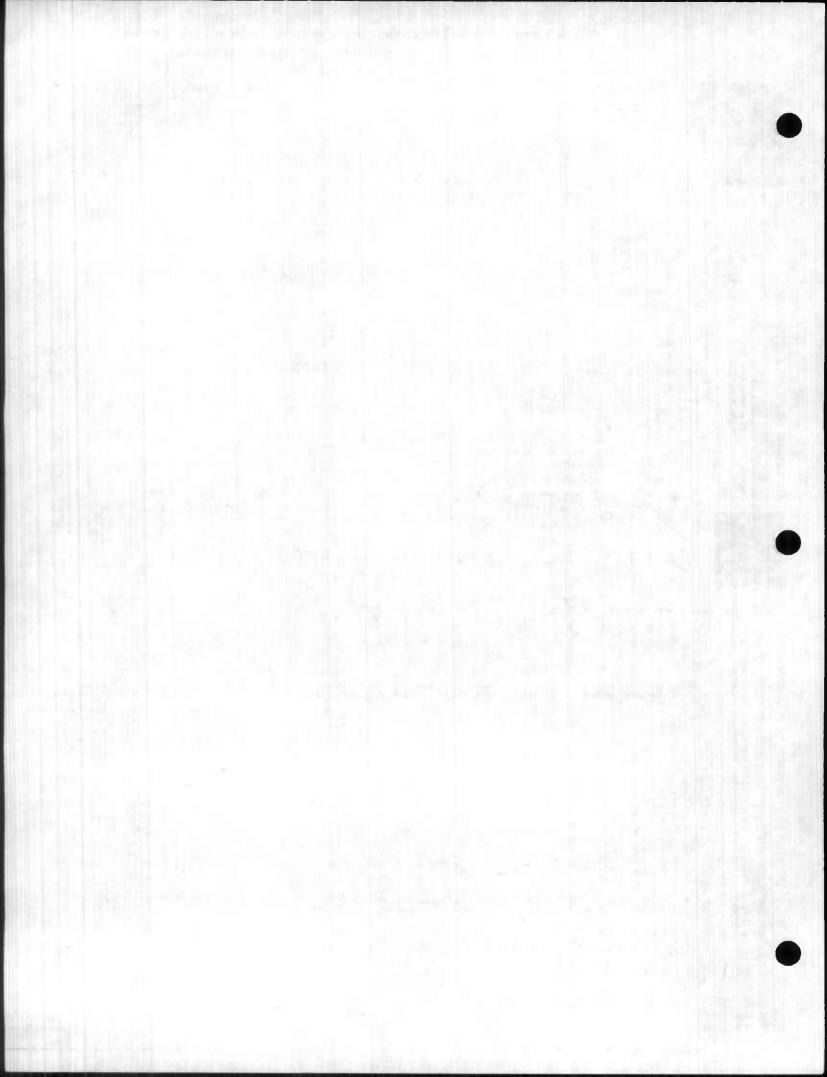
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Usuel Residence of Decedent 10e. Stete 10b. County Maryland Baltimo 10e. Street and Number 400 Georgia Cour	of MD The street end number)	rs. last birthdey) 7 Yrs.	If Under 1 Ye	TOWSC		r 27 2 4c. County of Baltin	more			
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Maryland Baltimo 10e. Street and Number 400 Georgia Cour		Oh: Tour sele			March 4		9. Birthplace (State or Fore Country) Maryland			
10e. Street and Number 400 Georgia Cour	re	City, Town or Lo					10d. Inside City Lim 1 ☐ Yes 2 ☑			
400 Georgia Cour	Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code					40-030	1			
4.4 Marital Chatra	Maryland Baltimore Towson 10e. Street and Number 400 Georgia Court 11. Meritel Stetus 1 Never Merried 2 Married 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Merried 2 Married 1 Never Merried 2 Married 1 Never Merried 2 Married 10e. Street and Number 10f. Zip Code 21204 11. Wes Decedent of Hispenic Origin? (Specify, Mexican, Puerlo Rich,						10g. Citizen of Whet Country? U.S.A.			
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	20h				1		tity or Town State			
	emoval from State	orraine	Park Ce	emetery	12-29-00	Woodlaw	n, Maryland			
21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Mary							Inc. and 21212			
disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest	Due to	o (or as e conseq	uence of):	·se (†			one wee			
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					10	ras 2 No	1 ☐ Yes 2 No			
25. Wes case referred to medical examiner?	124-1			A						
1 ☐ Yas 2X No 27. Mannar of Death	1 □ Inpatient 2		I SLI DOA	4CH MILEUR	7	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
2 Accident investigation 3 Suicide 6 Could not be detarmined		M 1 Yes 2 No			28f. Location (: City or Ton	28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)				
29b. Signeture end title of certifier	Attending	ms					(Month, Dey, Year) ~ 27, 2000			
30. Name and address of person who co	mpleted cause of deeth (It	tem 23e) (Type,	Print)	6 4.5	1 11	3 22	21204			
.//										
	Elamantary/Secondary (0-12) 12 years 17. Father's Neme (First, Middle, Last) Robert Thomas Sca 19e. Informent's Name/Raletionship (Ty Laurie Gibb 20e. Method of Disposition 1 Burial 2 Cremetion 3 Report	Elamantary/Secondary (0-12) 12 years 17. Father's Neme (First, Middle, Last) Robert Thomas Scarborough 19e. Informent's Name/Raletionship (Type, Print) Laurie Gibb 20e. Method of Disposition 1	Secondary (Secondary (6-12) 12 years 17. Father's Neme (First, Middle, Last)	Homemake 12 Years Homemake 13 Years Homemake 14 Years Homemake 15 Robert Thomas Scarborough 19e. Informent's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Str. 400 Georgia 40	Homemaker 12 years 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 18. Mother's Name/Raletionship (Type, Print) 19b. Mailing Address (Streat and Number or 400 Georgia Ct. To 20b. Method of Disposition 18 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Neuron of Cernetery, cremetory or other plece) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Mitchell—Wiedefel 6500 York Road 22a. Mather or 18 Sequentially list conditions, of near failure. List only one cause on each line. 22b. Plact of the Wiedefel Gesuch of the Hallure and Seaso or condition resulting in death) 25b. The office of the Wiedefel Accuse (Disposition of Neuron of Control of Sequentially list conditions, and office of the Wiedefel Accuse (Disposition of Neuron of Control of Sequentially list conditions, and office of the Wiedefel Accuse (Disposition of Neuron of Sequentially list conditions, and office of Sequentially list c	Elamantary/Recondary (0-12) College (1-4or 5+) Homemaker	Total Park Name (First, Middles, Last) Homemaker			



Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dev Year JOHN RICHARD SUIT DECEMBER 31,2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A BALTIMORE STELLA MARIS HOSPICE AT MERCY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) 1 € M 2 □ F Months Days Hours 56 218-42-6390 Nov.07 1944 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits n/a Baltimore 1 XYes 2 No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 USA 1518 Boyle Street 12. Was Decedent Ever in U,S. Armed Forces? 1 ™Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Highway Admin. Engineer Tech. 0 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Anna Henrietta White Harry Elmer Suit, Jr. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1518 Boyle Street, Baltimore, Md. 21230 (Wife) Betty Lou Suit 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Green Mount Cemetery 01/04/2001 Baltimore, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Esophusenl Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause 1 Yes 1 Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specifity > 114 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

attending physician and for use as the burtal-tran Box 68760 Division of Vital Records, P.O. ĝ signed by to d be detach page 2 certificate has After this Attending after death Director: within 29 hours a To the Funeral Completely filled

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

ed other than "natural", or itsms 23s or 28s-f show event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

filled within

Hygiene.

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permit. Pages 1 and 2 st Department of Health and Important. If Nem 27 is or any injury or other traum

Physician

/Medical

Examiner

Physician/Medical Examiner

by

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Certification:

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is marked

1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M

29c. License number D40854 29d. Date signed (Month, Day, Year) 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) StPWI Baltmer

31. Date filed (Month, Day, Year) State

(Check only one)

.IAN 03 2001





DHMH 16 Rev 6/95

Registrar

SV 4-34-

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Year Physician Anna Mae Suter 2000 11'0579 December 30 /Medical 4e Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Charlestown Nursing Center Catonsville Baltimore Co. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 6. Sex 1 M 2 F If Under 24 Hrs 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 91 Yrs. 212-56-7811 Director 10, 1909 Maryland Usual Residence of Decedent the Meryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits herra 23s or 28s-f show 1 Yas 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3014 Kenyon Avenue 21213 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Giva Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status permit. Peges 1 and 2 should be filled within 72 hours effar of Department of Health and Mental Hygiana. Introcramt: if flem 27 is marked other than "natural, or her any Injury or other traumatic avent, the Medical Ferr 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 20 White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 yrs. 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Nama (First, Middla, Last) Be Fischer Sarah J. Franz Bernard A. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Son 3633 Ady Road Street, Maryland 21154 Mr. Thomas J. Suter 20a. Method of Disposition 20b. Place of Disposition (Name of cematary, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 A Burial 2 Cremation 3 Removal from State 1/04/2001 Baltimore, Maryland Most Holy Redeemer Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Micas Carrey f. LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel DAYS disaesa or condition rasulting in death) Examiner Examiner be executed physician and the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of) 88 987 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 中 signed by t 1 Yes 2 TNo 3 Probably 4 Unknown by 24b. Wara autopsy findings evailable prior to completion of causa of daath? 24a. Wes an autopsy performed? Completed peeu 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: director. 25. Wes case refarred to medicat axaminer? Be 26. Place of Deeth (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 9 1 | Inpatient 2 | ER/Outpatient 3 | DOA funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? After 1 Naturel 5 Pending investigation n 24 hours after death.

The Funeral Director: After pletely filled in by the fur 1 Yes 2 No 2 1 Accident 28f. Location (Straat end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide Hospital to Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

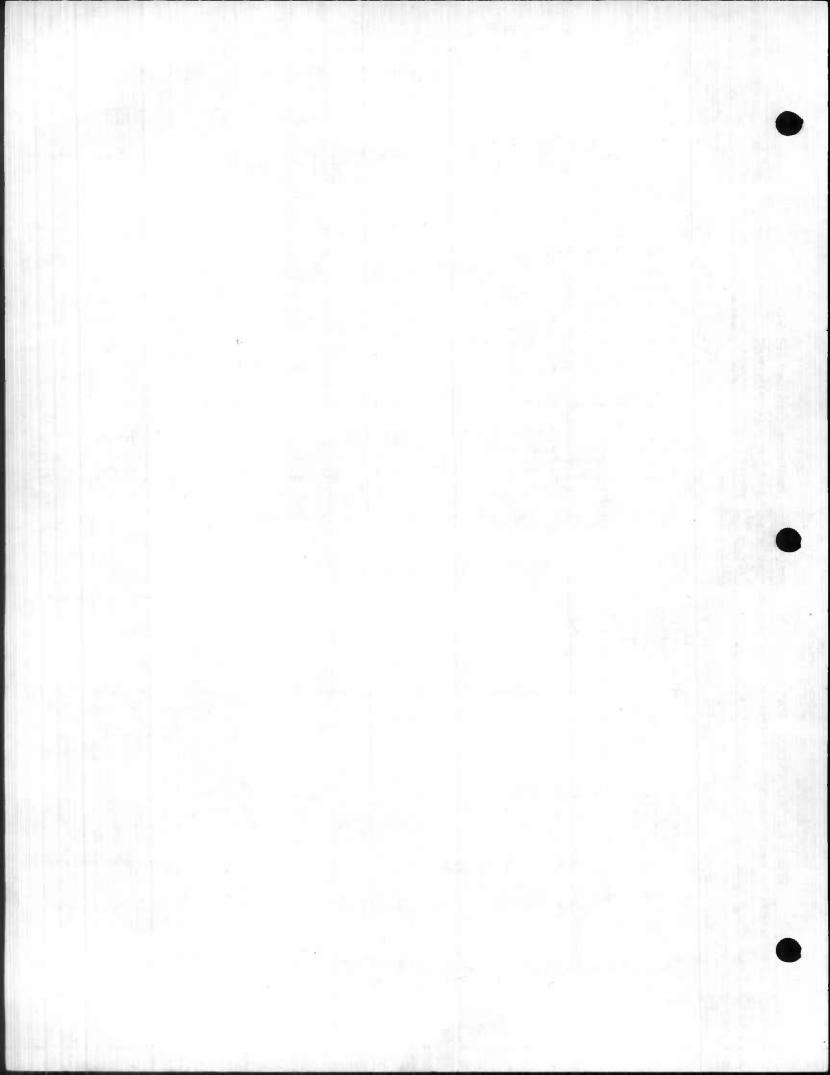
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. edical 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 31, 2000 26473 30 Name and address of person who completed cause of death (ttem 23a) (Type, Print) CHOICE CANE BALTOTO ZMIS Dernard. Loquorsky MAIPEN

State Registrar

31. Date filed (Month/Day, Year)

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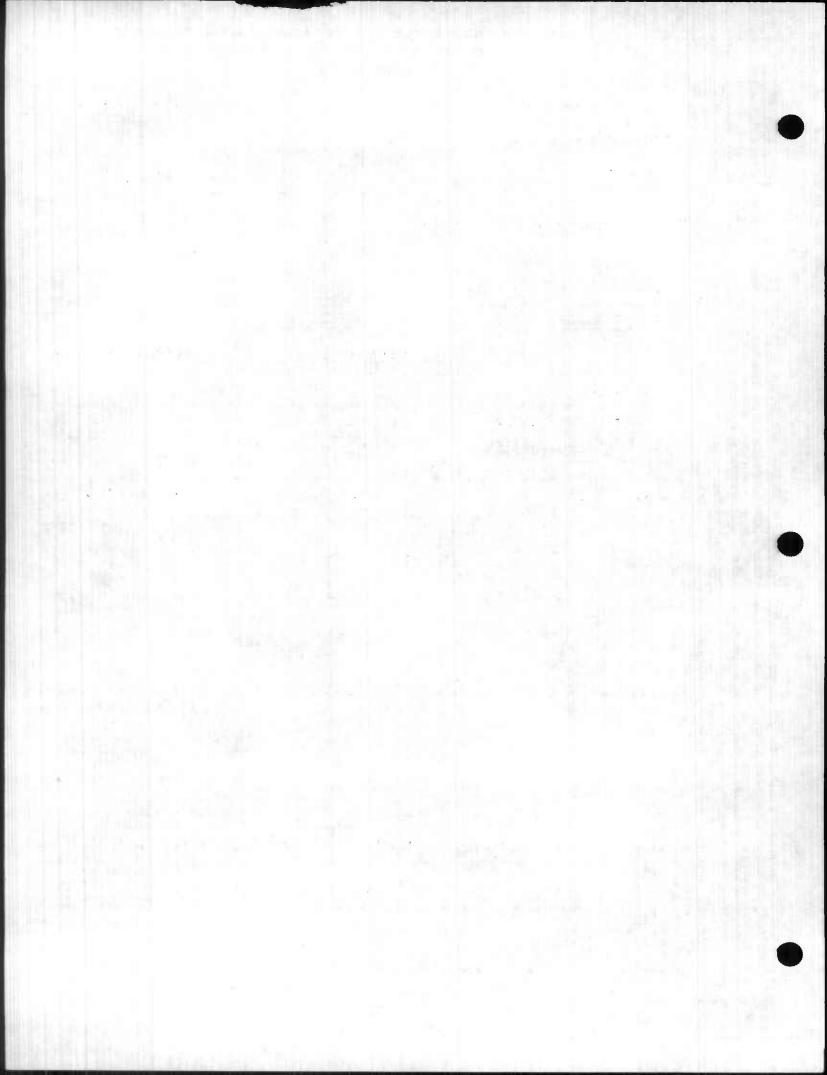
32, Registrar's Signature



SP			State of Marylan		artment of I rtificate of		Mental Hy	Reg. No.	42	086		
	Physician	1. Decedent's Neme (First, Middle, Last) Daniel John Slafkosky						2. Date of Death Month Dey Veer DECEMBER 30 2000 9:35 A				
	/Medical Examiner	4e Fecility Neme (If not institution, give s	4b. City, Town, or BALT IMOI	n, or Location of Death 4c. County of Deeth								
Funeral Director		097-66-2526	7. Age (In yrs. I	RAUMA 7. Age (In yrs. last birthday) If Under 1 Year Months Deys			s. 8. Dete of Bi (Month, Di Sept. 9	rth ey, Year) 1980	9. Birthpl Count Vew Yo	ace (State or Foreign Pry) OAR		
	Sa-f show	Usuel Residence of Decedent 10a. Stete 10b. County MD. Baltimore		r. Town or Lo	e					Od. Inside City Limits 1 ☐ Yes 2 🕱 No		
)36 irs after death with th it, or itema 23e or 28	uid be filed within 72 hours after death with the Maryland Mental Hyglana. rived other than "natural", or itema 23s or 28s-f show the event, the Hedical Exercitive must be motified at To Be Completed by Funeral Director	10e. Street and Number 214 Rosewood Avenue 11. Meritel Status 1XXIver Merried 2 Married 3 Widowed 4 Divorced	2 12. Wes Decedent Ever in U, Armed Forces? 10. Wyes 2 (i) No 17 48, Giva Yeer or Detes:	1	10f. Zip Code 21228 Wes Decedent of I Yes, specify Cub 1 Yes 20 No	an, Mexican, Pue	Specify Yes or Norto Rican, etc.)		ce - Americe ck, White, e	en Indien, atc.		
15-0	n 72 hc natur	15. Decedent's Educ (Specify only highest grade	cation a completed)	16e. Deced	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	16b. Kind of B	usiness/Ind	ustry		
Maryland 21215-0036	other of Hygin	Elamantary/Secondary (0-12) 12 17. Fether's Neme (First, Middle, Last)	College (1-4or 5+)		Marine	18. Mother's Ne	eme (First, Middle			2 Corp.		
	and man	David Slafkosky 19e. Informent's Neme/Reletionship (Tyr) David Slafkosky-			ng Address (Stree	t and Number or F		per, City or Town,				
Baltimore,	permit. Pages 1 and 2 Department of Haaith Important: If Item 27 It any Injury or other tra ence.	20e. Method of Disposition 1 X Buriel 2 Cremetion 3 R 4 Donetion 5 Other (Specify)	Loui	don Pa	sition (Name of natory or other pla rk Cemet	ery	01/03/ 2001	20c. Location	re.Ma	ryland		
Bal	pemit. Pa Department Important: any injury phice.	21. Signeture of Funeral Service License Nanda L Le	umer	16	30 Edmon	dson Ave	nue, Cat	tonsville				
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or complishock, or heart failura. List only on Immediata Causa (Finel diseasa or condition resulting in death)	Н	end I	njuries	ing, such es cardi	ac or respiretory (errest,		Approximete Intervel Between Onset end Deeth		
x 68760,	death certificate be assocuted e attending physician and ad for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate causa. Entar Undarlying Cause (Disease or Injury fhat initiated events resulting in death) Last		r as e conseq	Teles.							
P.O. Box	d by the state of	Pert II. Other eignificant conditions con	tributing to death but not resu	ulting In the u	nderlying ceuse gi	iven in Pert I.		Yee 22No	ontribute to	the cause of death?		
ecords law requiras	requir						peri	s en eutopsy ormed?	eve cor of c	era autopsy findings sileble prior to mpletion of cause deeth?		
/ital	ysician: Tha law lis cartificata has t i director, paga 2 s To Be Compi	25. Wes case referred to medical					eeth (Check only			7108 2010		
	± 60	1 ☐ Yas 2 ☐ No 27. Menner of Death	28a. Dete of Injury	ER/Outpetier 28b. Time of	I 3LI DOA		ing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred)		
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	1 Naturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	1 Naturel 5 Pending (Month, Day Year) Injury 2 Accident Investigation 3 Suicide 6 Could not be determined					In Volved in major Withcle Accident				
	To the Hospital or within 24 hours after To the Funeral Dir completally filled in Medical Cert		iclan: To the best of my knowner: On the basis of examinet				130 11m	a causa(s) end m	anner es st	AVYCANO!		
	within 2 To the compla	29b. Signeture and title of certifier	end menner steted.		29c. Licen O. C.	se number M.E		29d. Dete signe DECEMBE				
	6	30. Name and address of derson who co		23a) (Type,		Street,	Baltim	ore, Mar	yland	21201		

State Registrar

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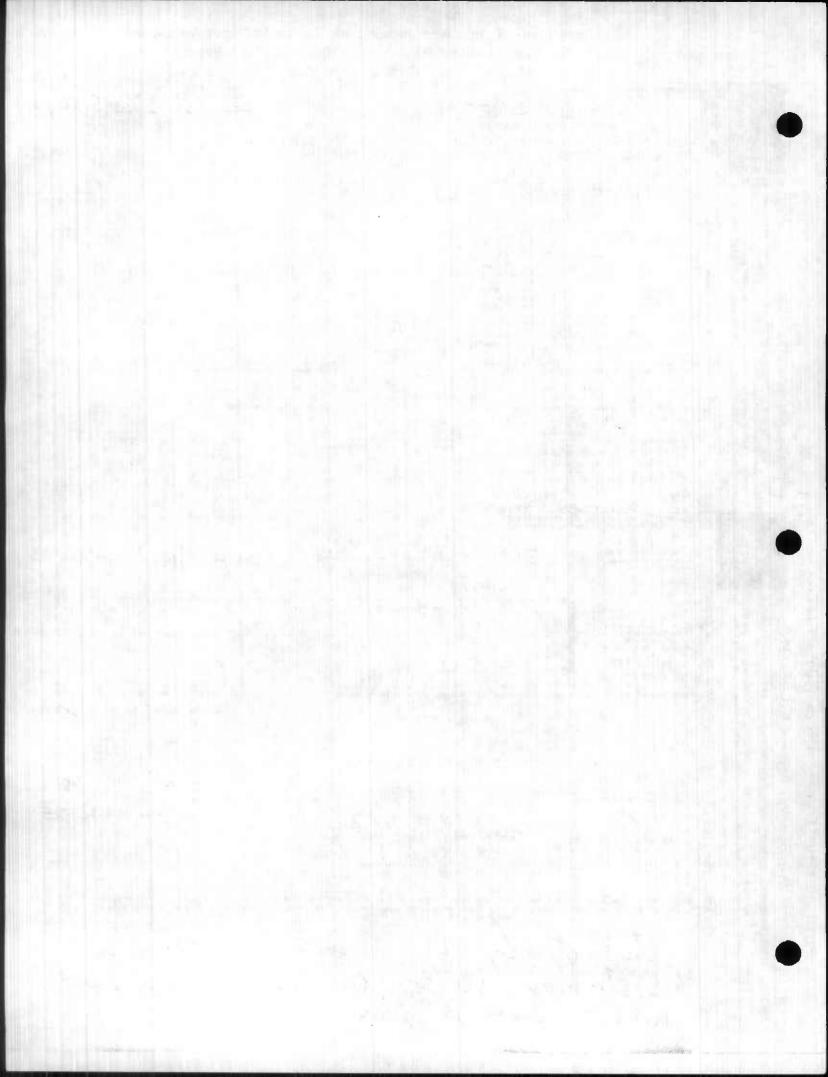
Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** :50 DEC 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Joseph Richie Hospice Baltimore If Under 1 Yaar If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□M 2XF Days Hours 87 Yrs. 319-56-7650 Sept. 18, 1913 Michigan Director Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Howard Columbia 1 Yas 2 XNo Directo 23a or 28a-1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 5408 Luckpenny Place U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 6 Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: SpecifiWhite à f Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) Coltega (1-4or 5+) 12 Housewife Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Surname) Freemond Schroeder Minnie Stube 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) William R. Smetak-Son 5408 Luckpenny Place, Columbia, Maryland 21045 riment of Health 20b. Place of Disposition (Name of cemetery, crematory or other place)

Raltimore/Washington
Crematorium 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.05, 2001 Laurel, Maryland 22. Nama and Addrass of Facility Witzke Funeral Home of Columbia 21. Signatura of Funeral Sarvice Licansea 5555 Twin Knolls Road, Columbia, Maryland 21045 23a-Part. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Ceuse (Final disease or condition rasulting in death) INTRA ABDOMINAL CANCER, UNKNOWN ORIGIN /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Last Due to (or es a consequance of): 68760, Dua to (or as a consequence of): es the Box (P.O. signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown of Vital Records, Be Completed by 24b. Were eutopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? has 1 ☐ Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No Medicai Certification: To 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of Injury at Work? I or Attending Patter death. Division 5 Pending invastigation Natural 1 Yes 2 No 2 Accident Director: / 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tely filled in by 4 Homicide Hospital 24 hours Funeral 29a. Cartifian prifying Phyeician: To the best of my knowledge, death occurred at tha tima, data and placa, and dua to tha cause(s) and menner as stated.

| Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) To the To the 29d. Data signed (Month, Day, Year) 29b. Signature and title ne and address of person who completed caus of Jeeth (Item 23a) (Type, Print) BALTIMINE MD 21229 20RMLD Day, Year 2001 32. Registrar's Sig State JAN 0 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Gloria Catherine Sands 30 2000 7:45 AM Dec. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Joseph Richie Hospice Baltimore If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 1□M 2X F Yrs. Maryland 215-34-8249 63 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Baltimore 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 21229 732 Bethnal Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Stetus 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify. 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Huber Agnes Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Straet and Number or Rural Route Number, City or Town, Stata, Zip Code) Rose Sands- Daughter 11900 Tarragon Road, Apt. F, Reisterstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 01/10/ □ XBurial 2 □ Cremation 3 □ Removal from Stete Arlington National Cemetery 2001 4 ☐ Donation 5 ☐ Othar (Specify) Arlington, Virginia 22. Name and Address of FacilityWitzke Funeral of Catonsville 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue, Catonsville, Maryland21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition rasulting in daath) Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disaasa or injury that initiated events Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 V 25. Was case referred to medical examinar? 26. Piaca of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5□ Residence 6 Dother (Specify) SEDINO 1 Yes 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred 28b. Tima of 5 Pending Investigation 2 Accident 1 Yes 2 No

28t. Location (Street and Number or Rural Routa Number, City or Town, State)

29d. Data signed (Month, Day, Year,

The lew requires that the death certificate be executed Division of Vital Records, or Attending Physician: s after death.

Physician

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Examiner

Funeral

Director

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Physician/Medicai Examiner

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Be Completed

Medicai Certification: To

3 Suicide

29a. Certifier

4 \ Homicida

29b. Signature and title of certif

6 Could not be

filed within 72 hours after deeth

Maryland 21215-0020

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the Medical Examiner must be notified at

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Funeral

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State Registrar

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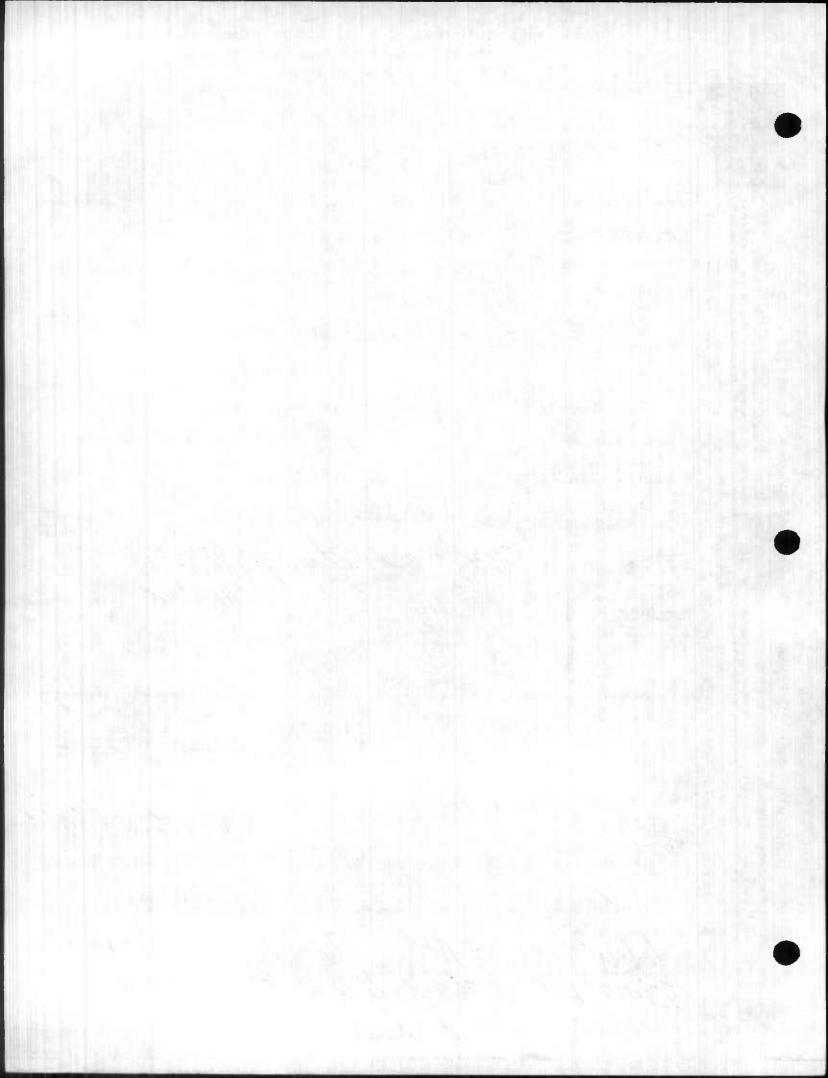
31. Date filed (Month, Day, Year)

32. Registrer's Signeture

28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

11 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.

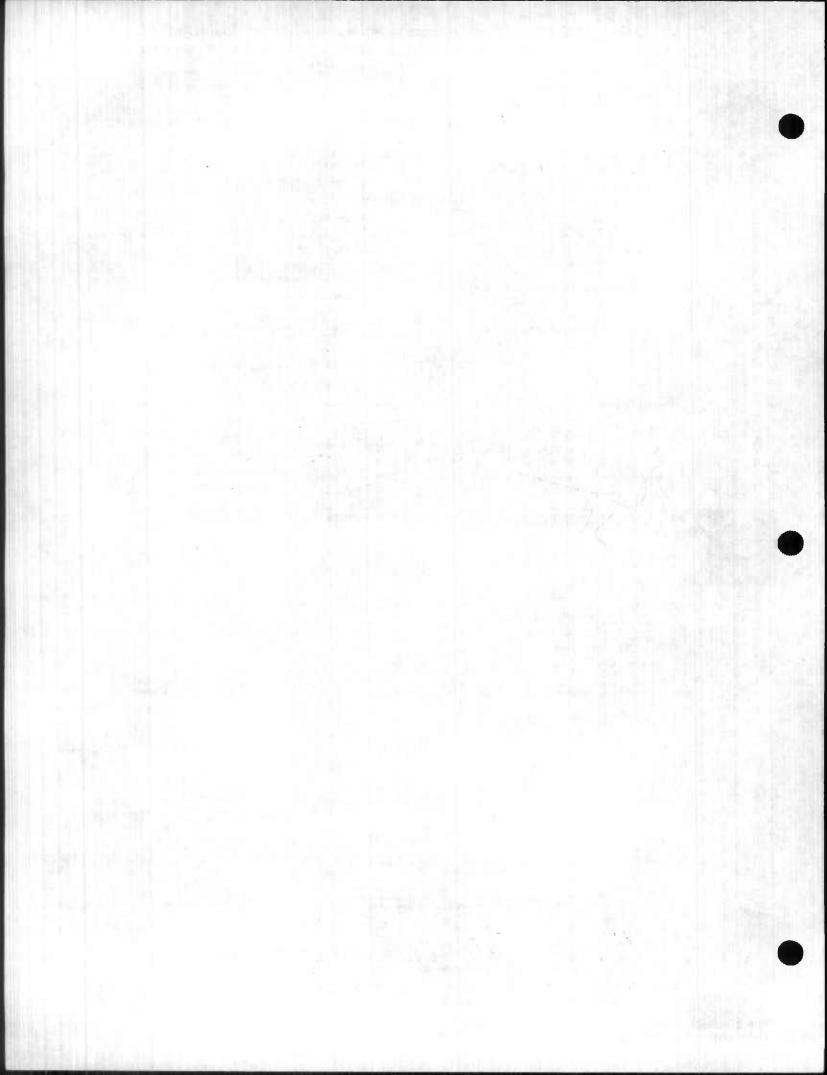


Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Death Day Month Year **Physician** Timoth 3.400 12 28 7000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 8. Date of Birth (Month, Dey, Year) 09 28 1960 Baltin N/A university 06 marylan If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 6. Sex **Funeral** 10 M 2 F Months Deys Hours Min. 183-48-2107 40 Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Heelth and Mental Hyglene.
Int: If Item 27 is marked other than "natural", or items 23s or 28s-f show Jry or other traumatic event, or Medical Examinating the notified as 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 KYes 2 No Directo PA Erie Erie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3908 Tuttle Avenue 16504 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Manager Restaurant 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be Charles Stepp Lorraine Washlaski 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3908 Tuttle Avenue, Erie, Pa. Sonya Stepp/ wife 16504 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If any injury or once. Erie, Pa Mary Queen of Peace Cem 01/03/01 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signifure of Puneral Service License 22. Name end Address of Fecility Sterling-Ashton-SchwabFuneral Home, Inc 736 Edmondson Avenue, Balto, Md.

or complications that caused the death. Do not enter the *mo*de of dying, such es cardiac or respiretory arrest, List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease of condition resulting in deeth) /Medical month troke Examiner Due to (or es e consequenca of): Examiner attending physicien end for use as the burial-trensit requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): resulting in death) Last signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably Dunknown Seizure Division of Vital Records, by 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of death? pege 2 s certificate has or Attanding Physician: after death. Director: After this certific 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1/2 Unpatient 2 ER/Outpatient 3□ DOA 27, Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 SNetural 2 Accident 5 Pending investigation 1 Yes 2 No filled in by the 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Fundamental or to the Fundamental Completely filled in Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es stated.

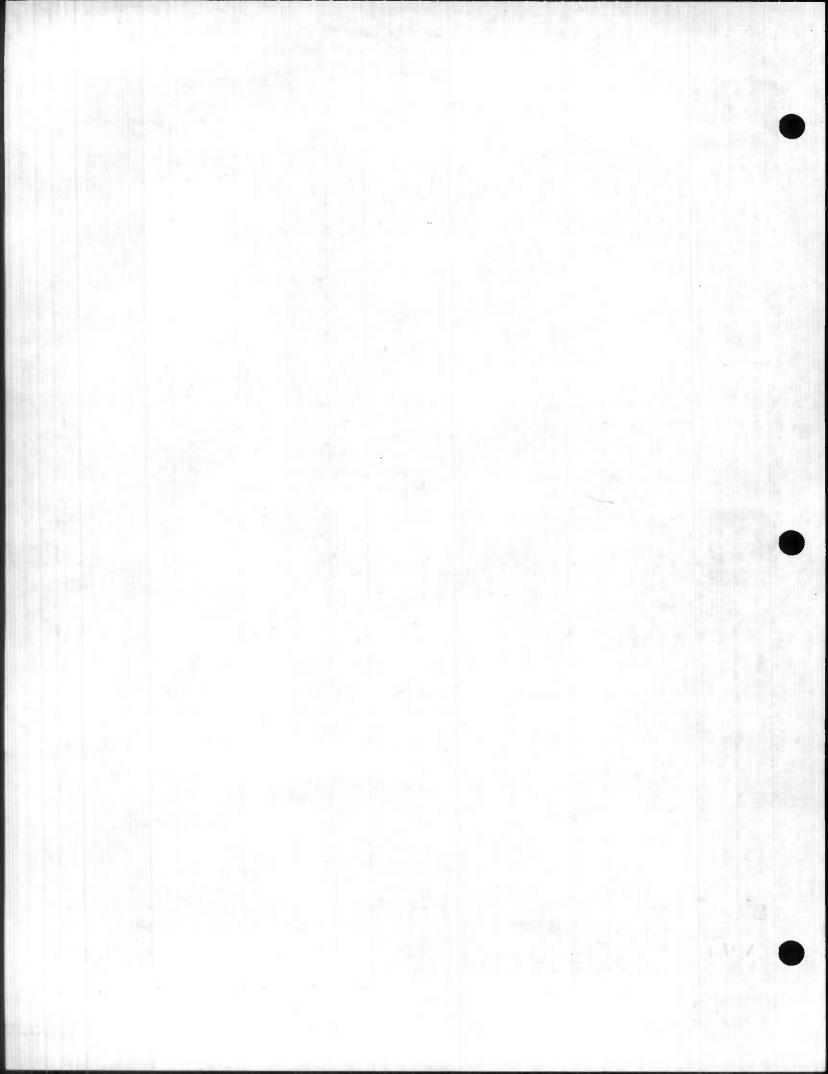
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier edical 29b. Signature and this of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Maryland, Neurology Bernesta Williams, MD universit 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar JAN 03

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State of Maryland / Department of Health and Mental Hygiene 1. 2 0 9

	Certificate of Death Reg. No.								
I LAKE I	1. Decedant'a Nama (First, Middle, Las.	0				2. Date of De	eath Day	3. Time	e of Death
Physician /Medical	William Erv	in Snyder				Decembe			54 AM
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town,	r, Town, or Location of Death 4c. County of Death			
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Funeral Director	290-34-0731	7. Age (In yrs. la M 2□ F 61	yrs. If Ur Mont	ths Days		Hrs. 8. Date of Bir Min. (Month, De	th ly, Year) 7, 1939	9. Birthplaca (Ste Watervill	le, OH
pud *	Usual Residence of Decedent 10a. Stata 10b. County	10c. City	Town or Location					10d insid	e City Limits
Aarylar r show	Maryland Worcest	Maria San San San San San San San San San Sa	hopville						res 2 □ No
ith the Maryla or 28s-1 short be nourised.	10e. Street and Number	JEI DIS		Zip Code			10g. Citizen of	What Country?	
deeth with the Maryland rms 23a or 28e-f show rms 15 or notified at neral Director	12623 Shell Mile	Road #17		21813	3		USA		
036 urs after al', or he member	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U,9 Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 61-6	If Yes,	ecedent of H specify Cub s 2 1 No	dispante Origin an, Mexican, P Specify:	? (Specify Yes or No uarto Rican, atc.)		ce - Amarican Indiar ack, White, etc. White	1,
21215-003 ed within 72 hours yglene. wr than "natural", ft, the Wolfeled by	15. Decedent's Edit (Specify only highest grad	ucation da completed)	16a. Decedent's U	Jsual Occup work done	ation during most of	working	16b. Kind of E	Business/Industry	
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Nore, Maryland 2 ges 1 and 2 should be filed to fleath and Mentel thy if item 27 is marked other or other traumatic event.	Urvin Snyder					Caroline			
should be not marked umatice.	19e. Informent's Neme/Reletionship (T	ivne Print)	19h Mailing Add	racs (Street	end Number o	or Rural Route Numb	er City or Town	State Zip Code)	
Mar nd 2 sho lith end 27 is me	Carl Snyder (son)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	9670 F1					ryland 21	701
Gore, Noses 1 and tof Health If New 27 or other tr	20a. Method of Disposition	20b. P1	ace of Disposition	(Neme of		Date		- City or Town, State	
Pa de	1 ⊠ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Wak	matery, crametory ceman Cem	etery	ess of Facility	01/03/01	Water	ville, Oh	io
Balt permit. Departrimportures any injecto.	21. Signature of Funeral Service Lound		Funeral Home, Inc. imore, Maryland 21228						
	23a. Part1. Enter the disease, or comp shock, or haart failure. List only of	licetions thet caused the death	. Do not anter the	moda of dyir	ng, such as car	rdiac or respiratory a	rrest,		mate Between
Physician /Medical Examiner	Immediete Cause (Final disease or condition resulting in deeth)	a. Hemop	ericardiu	m				Onset a	and Death
je je		Cardiac	Rupture						
executed in end ist-trensit	Sequentially list conditions,	D	as a consequenca						
LEX	Cause (Disease or Injury that mitiated events Due to (or as a consequence of):								
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death death defor u	Part II. Other eignificant conditions co	ntributing to death but not rasu	Iting in the underlyi	na cause ai	en in Part I.	23b. Dld	tobacco use c	ontributa to the cau	use of death
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has the mpl								of death?	
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OT VITAL Physicien: The certificate ral director, per certificate ral director	25. Wes case referred to medical examiner?	Hospital:		Otl	ner:	Death (Check only			
0 5 5 5	27. Manner of Death	1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 = 28b. Time of	28c. Inju	4 U NUISI	ng Home 5 ☐ Res 28d. Describe	how injury occu		
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of the function of the functin of the function of the function of the function of the function	3 Suicide 6 Could not be determined					Street and Num wn, Stete)	nber or Rurel Route I	Num <i>ber,</i>	
FF 183		sician: To the best of my know iner: On the basis of examinati							(ca/c)
Completely di	ane)	and manner stated.	on anwor myestige			occurred at the time.			
Me comple	29b. Signature and title of certifier	0011	TO STATE OF	29c. Licens	se number	7	29d. Date sign	ned (Month, Dey, Yea	11)
, MI	llenn	- Jehner		0.	C.M.E.		DECEMBE	ER 27, 200	00
/) / /	30. Name and address of person who	ompleted cause of death (Item	23a) (Type, Print)						
0 6	Dennis Chut	emo		enn St	reet, I	Baltimore,	Maryla	and 21201	
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrar's Signat	in B	200	extal				
7.03.01.41	11/2/11/	CULTURE AND ADDRESS OF THE PERSON ADDRESS		1 5					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** STOCKETT 31 DECEMBER 2000 8:07 pm LILLIE /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 10 M 20 F 96 Yrs. Director 218-42-7480 Feb. 29,1904 Maryland Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frama 23a or 28a-f ahow traumado event, the Medical Examiner must be notified at ₩yes 2 No Director MD N/A Baltimore 10e. Street and Numbe 10f. Zio Code 10a. Citizen of What Country? with 1714 N. Washington Street 21213 USA Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck White etc. 72 hours efter 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK p 3 Widowed 4 □ Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If Item 27 ie marked other than "natheny injury or other traumatic event, the Medical DRDs. Elementery/Secondary (0-12) College (1-4or 5+) 6th Domestic Private Families 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Thomas James Dorsey Laura Watkins 19e. Informent's Neme/Reletionship (Type, Print) Son 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Edward A. Stockett Sr. 4803 Tamborind RD. Balto. MD 21209

and Disnosition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition 20b. Placa of Disposition (Neme of cametery, cremetory or other place) Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Arbutus Mem. Pk. Cem 01/05 Baltimore., MD

22. Name end Address of Fecility Nutter Funeral Home Inc. 21. Signeture of Funeral Service Licensee 2501 Gwynns Falls Pkwy. Balto. MD 21216 Herbert 8 nutter 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting In deeth) /Medical tachycardia bradycardia syndrame week Examiner Examiner Uzheimers dementica Vear attending physician and for use as the burlel-transit that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequença of) Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by the detached Division of Vital Records, P.O. 1 Yes 2 4 No 3 Probably 4 Unknown Diabetes à The lew requires 24b. Were eutopsy findings eveilable prior to completion of cause of death? should I 24a. Wes en eutopsy performed? Completed hes 39 2 8 eged 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this After this 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death Certification: 28c. Injury et Work? Attending 5 Pending Investigation 1 Neturel stardeath.

Director: Afrid in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò To the Purple of 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated. 29a. Certifier (Check only 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shannen **RES 000** rimeu mi 30. Name and address of person who completed cause of death (Ham 23a) (Type, Print) SHANNON PUTMAN Baltimore, Maryland 1830 Building East Monument Street, Room 9020, Baltimore, Maryland

State Registrar 31. Defe filed (Month, Day, Year) IAN 03 32. Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene

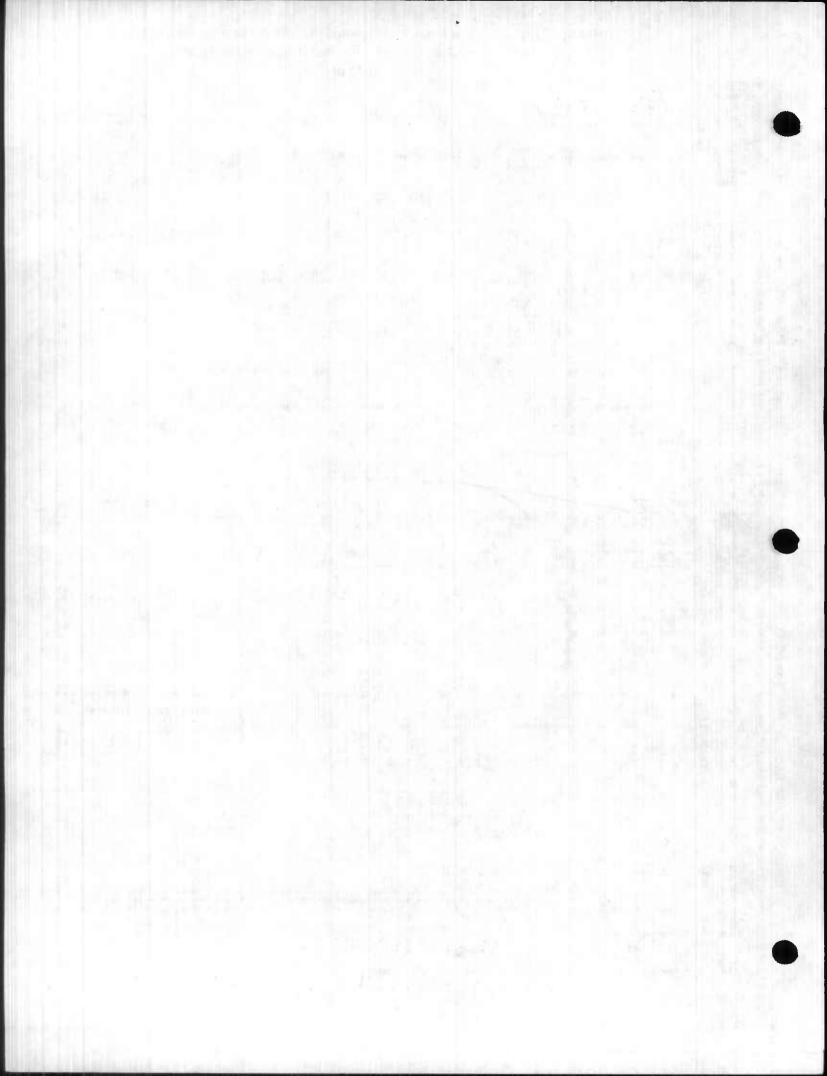
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death RuthSchne **Physician** DEC. 28, 2000 5:30 P.M. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 8522 OAK ROAD RIDGELEIGH BALTIMORE If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Devs Hours 1□M 20 F Yrs. Director 212-09-9622 8] 10/24/1919 PENNSYLVANIA Usual Residence of Decedent filed within 72 hours efter death with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Expresser must be notified at 1 ☐ Yes 2 No Director BALTIMORE RIDGELEIGH 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 23a or 2 RUTH SCHUELER 21234 Funeral 8522 OAK ROAD USA Hema 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 6 1 Yes 2 No Specify þ 3 □XWidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) 12TH GRADE HOMEMAKER OWN HOME Saltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Peges 1 end 2 should be nant of Health and Mental int: If Item 27 is marked o MARGARET SCHECKLES JOHN KRANTZ 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 303 PATAPSCO AVENUE BALTIMORE, MD BEVERLY R. LACOTTI DAUGHTER other 20b. Ptace of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Surlel 2 □ Cremetion 3 □ Removel from Stete Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) MEADOWRIDGE MEM. PK. 1/2/01 ELKRIDGE, MD 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee THE JOHNSON FUNERAL HOME, P.A. TOWSON, MD 8521 LOCH RAVEN BLVD. 21286 23. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximete Intervet Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Box 68760, Due to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? be datached 1 Yes 2 No 3 □ Probably 4 □ Unknown signed by þ Division of Vital Records, 24b. Were eutopsy tindings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed egad 1 ☐ Yes 2 ☐ No 1 Yes al or Attanding Physician: The safer deeth.

In Director: After this certificate of in by the funeral director, page in by the funeral director, pages. Certification: To Be 25. Was case reterred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 5 Residenca 6 □Other (Specify) 28a. Dete of injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred Injury et Work? 5 Pending investigation Neturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide To the Mospital (withinted hours a To the Funeral D TEX Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier end manner steted 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signeture and title of certifies 00 30. Neme end address of person who completed cause of deeth (ttem 23a) (Type, Print) 31. Dete tiled (Month, Day, Year) 32. Registrer's Signeture State Registrar

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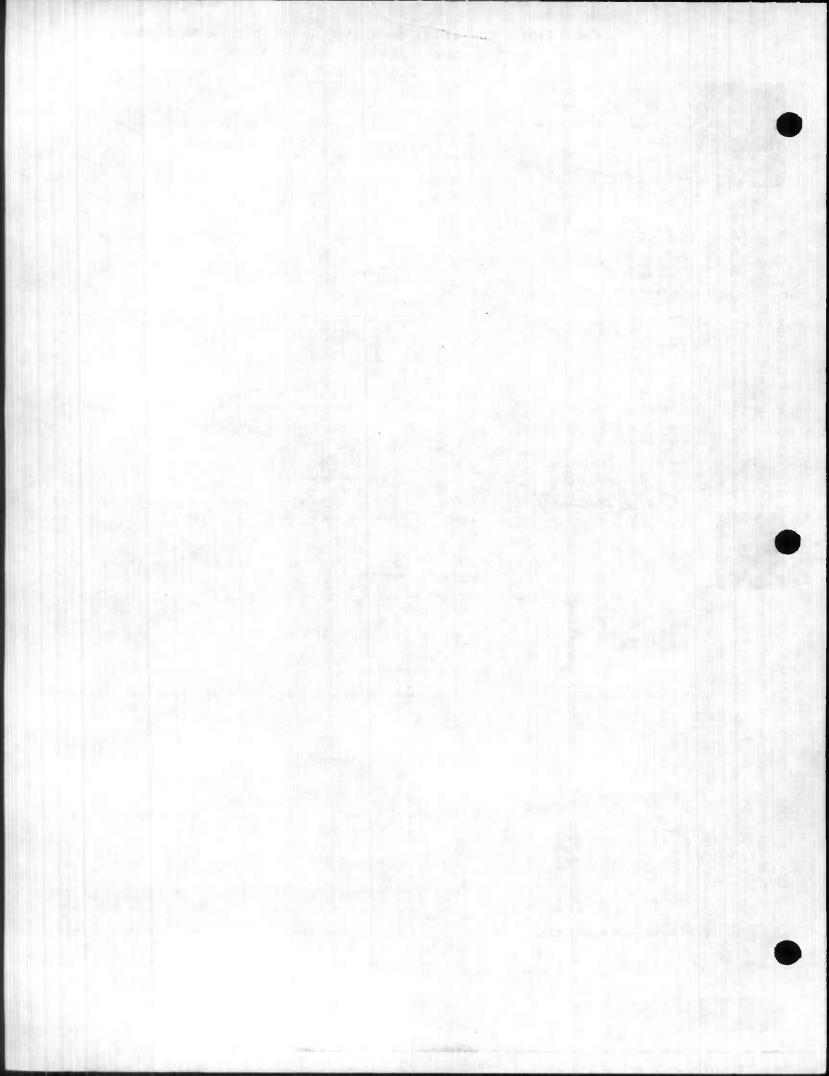
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** DEC 2000 6:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner HOSPICE NIA BALTIMORE 8. Date of Birth (Month, Dey, Year) NOV. 05, 1933 If Under 1 Yeer 9. Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Deys 1 M 2□ F 212-34-5920 Usual Residence of Decedent SOUTH CAPOLINA Director 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County or 28a-f ahow the Medical Examiner must be notified at Yes 2□No Funeral Directo MARYLAND 10e. Streef and Number 10g. Citizen of What Country? STREET Nema 23a 6 filed within 72 hours after death 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Merifel Status 1 ☐ Yes 2 No If Yes, Give 6 1 ☐ Yes 2 ☑ No Specify: BLAC py 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) OTHGRADE other Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Peges 1 and 2 should be fil ment of Health and Mental H tant: If item 27 is marked off LOR 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. fntormant's Neme/Reletionship (Type, Print) SIGNIFICANT 20b. Place of Disposition (Name of cemetery, cremetory or other piece) BALTIHORE, MD. 21230
Dete 20c. Location - City or Town, State OTHER Baltimore, 20e. Method of Disposition

10 Buriel 2 Cremetion 3 Removel from State ò permit. Pege Department of Important: If any injury or pace. 4 ☐ Donetion 5 ☐ Other (Specify) 01-03-01 ('EMETERY LANSDOWNE, MARY 22. Name and Address of Fability JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, 140. 21217 21. Signeture of Funeral Service Licansee Approximate Intervel Between Onset end Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respirator, shock, or heer failure. List only one cause on each line. **Physician** /Medical fmmediate Ceuse (Final 2 Dag diseese or condition resulting in deeth) Examiner Due to (or es e consequenca ot) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24a. Wes en eutopsy performed? 24b. Were eutopsy tindings aveilable prior to completion of cause of deeth? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Division of 28c. fnjury et Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of Beturel 5 Pending Investigation after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) 29a. Certifier (Check only one) end menner steted 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of contile 0/4221 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Prinf) 223 B. Blun BALT on 4271 4221 my 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture Registrar 3 200

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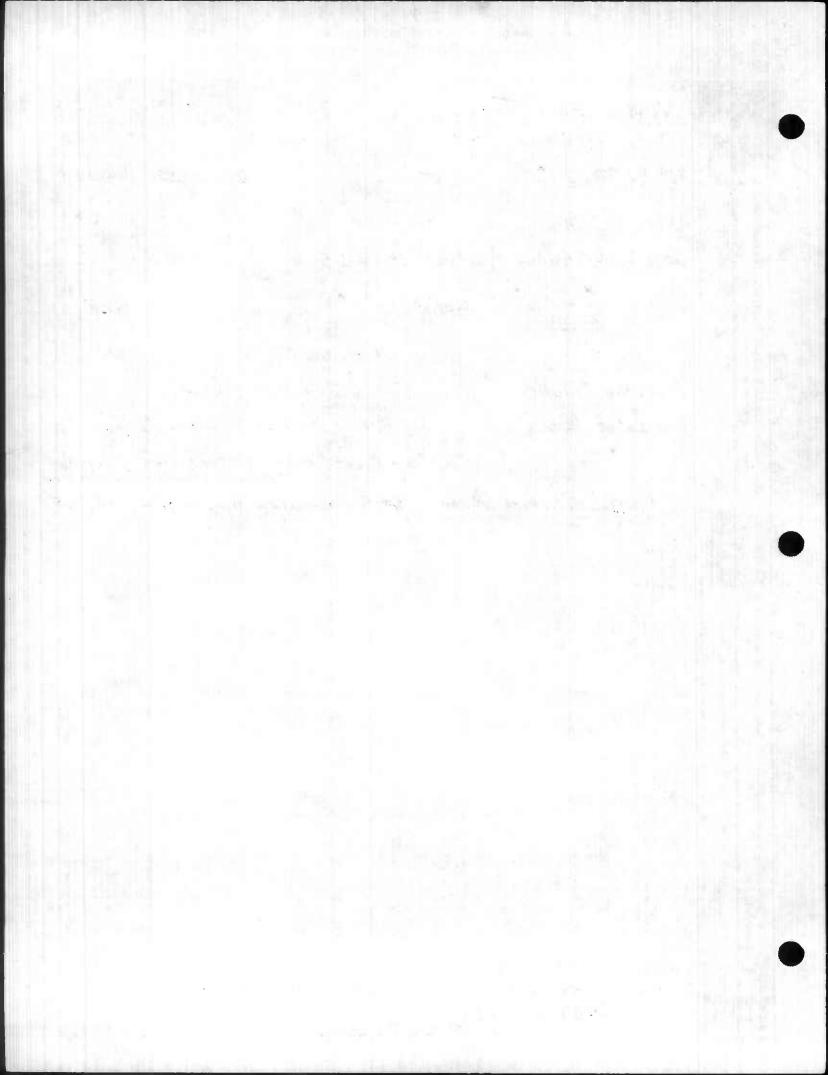
JAN 0 31. Dete filed (Month. 3 2001

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Jules

32. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of Ma		epartment of I Certificate of			giene Reg. No. 0	42	095			
	1. Decedent's Name (First, Middle,	Last)			2. Date of Dea			Time of Death				
Physician	Shirley Tams					Decembe	er 30.	Year 2000 6	:56 a.m.			
/Medical Examiner	4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of De											
Examine	1227 N. Luzerne	Avenue			Baltimo	re	1	1/4				
Funeral		Sex / 7. Age	(In yrs. last birtl	nday) If Under 1 Year Months Days		8. Data of Birth (Month, Day	h Voor)	9. Birthplaca	(Stata or Foreign			
Director	223-14-2557 Usual Rasidance of Decedant	102M 2DF	74 Y	rs. Months Days	Tiodis IVIII.	6-16	-1916	Country	VA			
show	10a. Stata 10b. County	,	10c. City, Town	or Location				10d.	Inside City Limits			
28a-f st nouthed	Maryland	//A Baltimore						1 Yes 2 No				
rms 23e or rms be neral Di	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?				
	1227 N. Luzerne	Avenue		21	213		US.	A.				
	11. Meritel Stetus	12. Wes Decedent E	ver in U,S.	13. Was Decedent of I If Yes, specify Cub		ecity Yas or No-	14. Rac		- Amarican Indian,			
		Armed Forcas?	1942	1 Yes 2 No		Hican, atc.)		ck, White, etc.				
ygiene. nr then "netural", or ite nt, me Healen Examin Completed by Fu	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Year or Datas:	Specify:		Specify	BLA	CK					
	15. Decedent's (Specify only highast of		1945 16a.	Decedent's Usual Occur	pation during most of work	ina	16b. Kind of B	usinass/Indust	гу			
	Elamantary/Secondary (0-12)	Collega (1-4or 5+)	(Give kind of work done life. DO NOT use retire		INDUST						
	12 th GRADE	NA		LABORE					7			
Be vot	17. Fethar's Nema (First, Middle, La	st)	18. Mother's Name		Maiden Suman	na)						
To etc												
le mar	19a. Informant's Name/Ralationship				The state of the s							
n 27	HORTENSE WATKINS 1227 N. LUZERNE AVE BALT MD 212/3 20a. Mathod of Disposition (Nama of 1,14). Data 20c. Location - City or Town, Stata											
or of	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3	☐Ramoval from Stata		Disposition (Nama of crematory or other pla		Data						
4 3 9 2	4 Donalion 5 Other (Spec		GARA	2150N FOR	ESTCEM	1/4/01	OWING	5 mil	4 mD.			
Depertmen Important: any Injury once.	21. Signature of Funaral Sarvica Lic	anses	1-	22. Nama and Addre	ass of Facility	1 40	in t=					
6620	Qual 1	Komari	ce	BETTS 1129 N.	CAROLI	NE ST	B44	6. m D	2/2/3			
-	23a. Part Enter the diseasa, or co	mplications that caused to	he daeth. Do n					Ap	proximeta arval Between			
ysician	0							On	set and Death			
Medical	Immediata Causa (Final diseesa or condition	Arteri	osclero	tic Cardiov	isease		14	/ears				
caminer	rasulting in daath)	a	ua to (or as a c					1				
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in and tel-transit	Sequentially list conditions. Dua to (or as a consequence of):											
he he	that initiated events rasulting in death) Last	C	ua to (or as a co	onsequence of):								
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tend or us		0				112.7		1				
by the a	Part II. Other significant conditions	contributing to death but	not rasulting in	tha underlying causa gi	ven in Part I.	23b. Dld t	obacco use co	ntribute to the	cause of death?			
detach detach	Dementia					101	Yes 2 No	3 Probabl	y 4 Unknowr			
be de by F	Demerrora											
been si should l	Peripheral Vasc	ular Disease	2			24a. Was perfo	an autopsy rmed?	availat	autopsy findings ble prior to			
has be ya 2 sh mple								of dear	etion of cause th?			
	Seizure Disorde	r				101	as 2 No	1 🗆 Ya	s 2 No			
certificate	25. Was case raferred to medical examinar?				26. Place of Deat	h (Check only o	ne)					
0 0 0	examinar?	Hospital:		Ot	her:	- Arts						

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral d Division of Medical Certification:

27. Mannar of Death 28b. Tima of Injury 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 1 XNatural

5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datamined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29b. Signatura and titla of cartifian 29c. License number 29d. Data signed (Month, Day, Year)

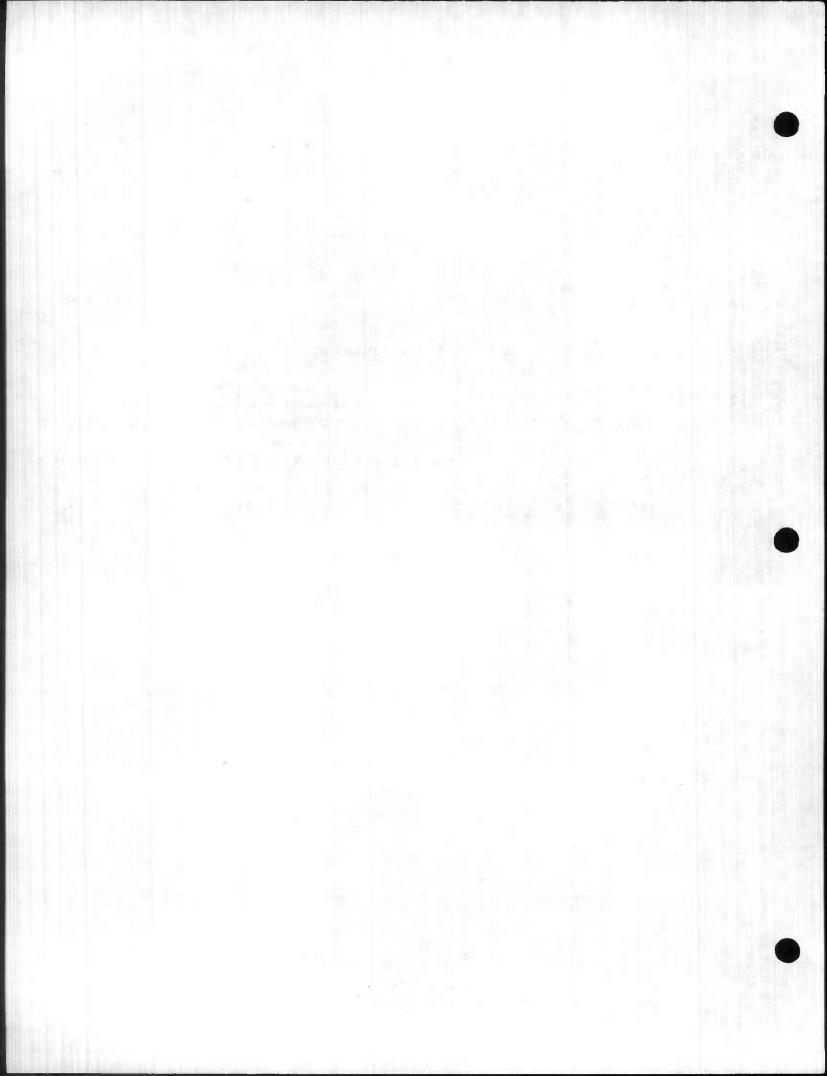
30. Nama end eddrass of person who completed causa of death (Item 23a) (Type, Print)

Dorothy Snow, M.D., 10 N. Greene Street, Baltimore, MD 21201

State Registrar

4 Homicida

32, Registrat's Signatura



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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THOMAS JR.

Physician /Medical

Funeral Director

Directo Examiner must be Funeral 72 hours after "natural", or Completed the Medical filled within Hygiene. should be Mental pekram s 1 and 2 s of Health s I flam 27 i

Baltimore, Maryland 21215-0036

Pages 7

Physician /Medical Examiner

attending physician and for use as the buriat-transit The law requires that the death certificate be executed Records, P.O. Box 68760. ed by the a signed by should b page 2 a certificate Division of Vitai Physician: director this After Hospital or Attending death Director: / To the Hospital within 24 hours a To the Funeral Completely filled

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year Leo Thomas, Jr. DECEMBER 28,2000 10:02P.M 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Undar 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 1 M 2 □ F Months Days Hours 68 187-24-0675 02-21-1932 MD Usual Residence of Decedent 10a, State 10h Counts 10c. City, Town or Location 10d. Insida City Limits Yas 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 519 S. Bradford Street 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give ¹ Year or Datas: Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. 1 Never Married 20 Married 1 Yes 2 No Specify Specify: Caucasian by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Longshoreman I.L.A. 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Leo Thomas, Sr. Mary Abromowicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Theresa Thomas 519 S. Bradford Street, Baltimore, MD 21224 20b. Place of Disposition (Name of cemetary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 1-03-01 Balto., MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Lity 22. Nama and Addrass of Facility Kaczorowski Funeral Home, P.A. responenthe raclis 1201 Dundalk Avenue, Baltimore, MD 21222 23a. Part1. Entar tha disease, o shock, or heart failure. Lim Approximate Interval Batween Onset and Death vations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se cause on each line. Immediate Cause (Final disease or condition resulting in death) a Arteriosclerotic Cardiovascular Disease Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying-cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 18 case à 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed INSPECTION 1 ☐ Yas 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2√ ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 (XNatural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29s. Cedities 29b. Signatu 29c. Licansa number 29d. Date signed (Month, Day, Year) O.C.M.E. DECEMBER 29,2000 and address of person who completed cause of death (Item 23a) (Type, Print) 30. Nan

State Registrar 31. Date filed (Month

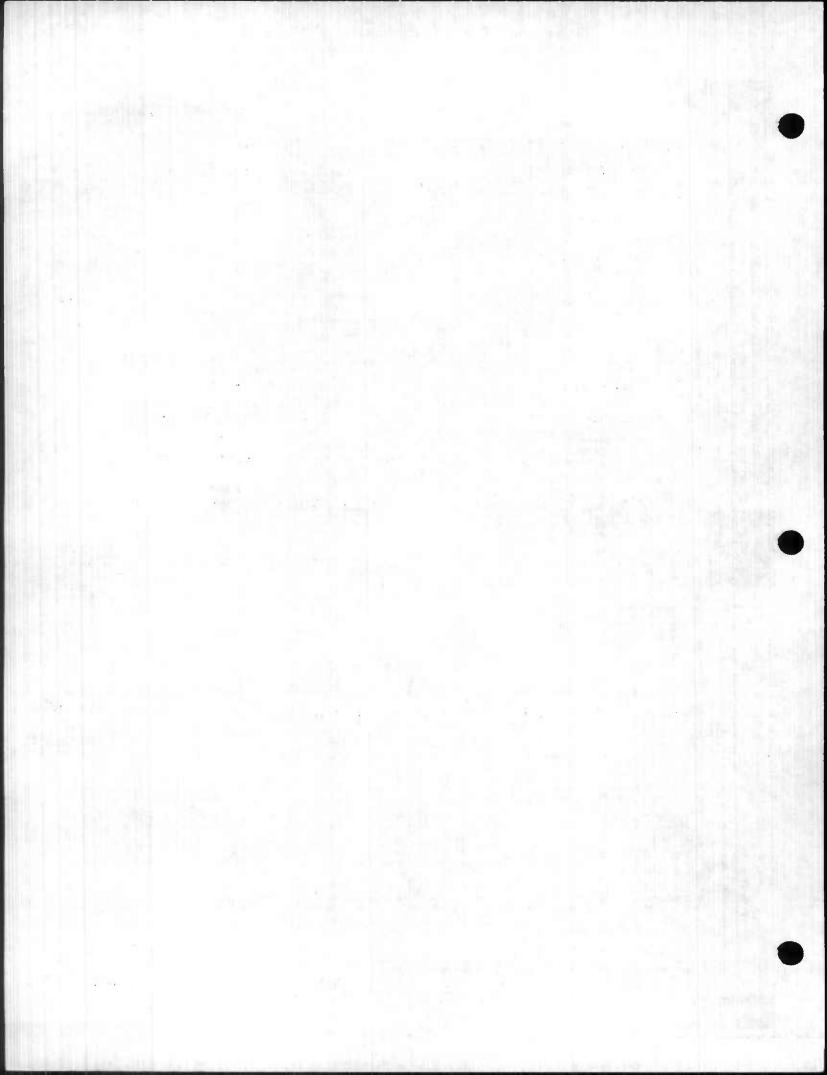
DHMH 16 Rev 6/95

ORIGINAL

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32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) : 35 pm Irue heart December 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospice INC oseph If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 15 M 20 F Days Hours 216-02-8887 Usual Residence of Decedent 32 Yrs. Amusey 20, 1968 MARGIAND 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BAHIMORE none HARwand 10e. Steet and Number 10g. Citizen of What Country? 10f. Zip Code USA Stam 21229 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yes 2 No 3 Widowed 4 Divorced American TICAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12H none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hawthome Deloris HERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BAHIMOR, MARyland Deloris Hawthorne (mother) Stamford Ave. 20b. Place of Disposition (Name of cametery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cathedral 21. Seneture of Funeral Service Licensee 22. Name and Address of Facility WALLACE FUNERAL SERVICE LANCY M. WALLACE, 3405 W. FRANKIN St. 23a. Part1. Enter the Assass, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart filters. List only one cause on each line. Battimerez md 21229 Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting In deeth) Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequenca of): thet initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 2 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 Delo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medica 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes /2000 28a. Dete of Injury (Month, Day Year) 27. Manger of Death 1 E Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide

P.O. Anthony

Physician/Medical Examiner þ Medical Certification: To Be Completed

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Director

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Physician

/Medical **Examiner**

Pages 1 and 2 nt of Health : If hem 27 i

Maryland 21215-0020

Saltimore.

it or Attending Fatter deeth. Director To the Hospital within 24 hours a To the Funeral D

29a Certifier

6 Could not be determined 4 Homicide

28e. Placa of tnjury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

32. Registrar's

State Registrar

2001 JAN - 3 PM 12: 43

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Dey Year December 30 2000 4:30 A.M. Josephine Theresa Toro 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Easpoint Nursing Home Eastpoint Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) 04/28/1914 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Days Months 10M 20F Hours 220-22-5764 86 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Dunda1k 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 32 Liberty Parkway 21222 united States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Bleck, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 DLNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondery (0-12) College (1-4or 5+) Principal School System 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Charles Toro Theresa Dotolli 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister 8603 Tower Bridge Way Rose Hineman 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete 1/3/00 Oak Lawn Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow spring Road, Dundalk MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approx Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) alm Due to (or as a consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work?

Examiner physician and the burial-transit The law requires that the death certificate be executed Physician/Medical 88 980 Ö ed by the a Š Completed After this certificate has to funeral director, page 2 s Physician: Be 2 Director: After thi Certification: or Attending To the Ho

Physician

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7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examinar must be notified at

Hygiena. other than "natural", or

and Mental Hygi

Pages 1 and 2 should be fill ment of Health and Mental Hy lant; If Item 27 is marked oth

permit. Pages Department of Important: If its any injury or or

Physician /Medical

Examiner

the Maryland

72 hours after death

filed within

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 16 Rev 6/95

4 Homicide (Check only one)

6 Could not be determined

1 Natural 2 Accident

3 ☐ Suicide

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 Yes 2 No 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Baltimore

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner stated.

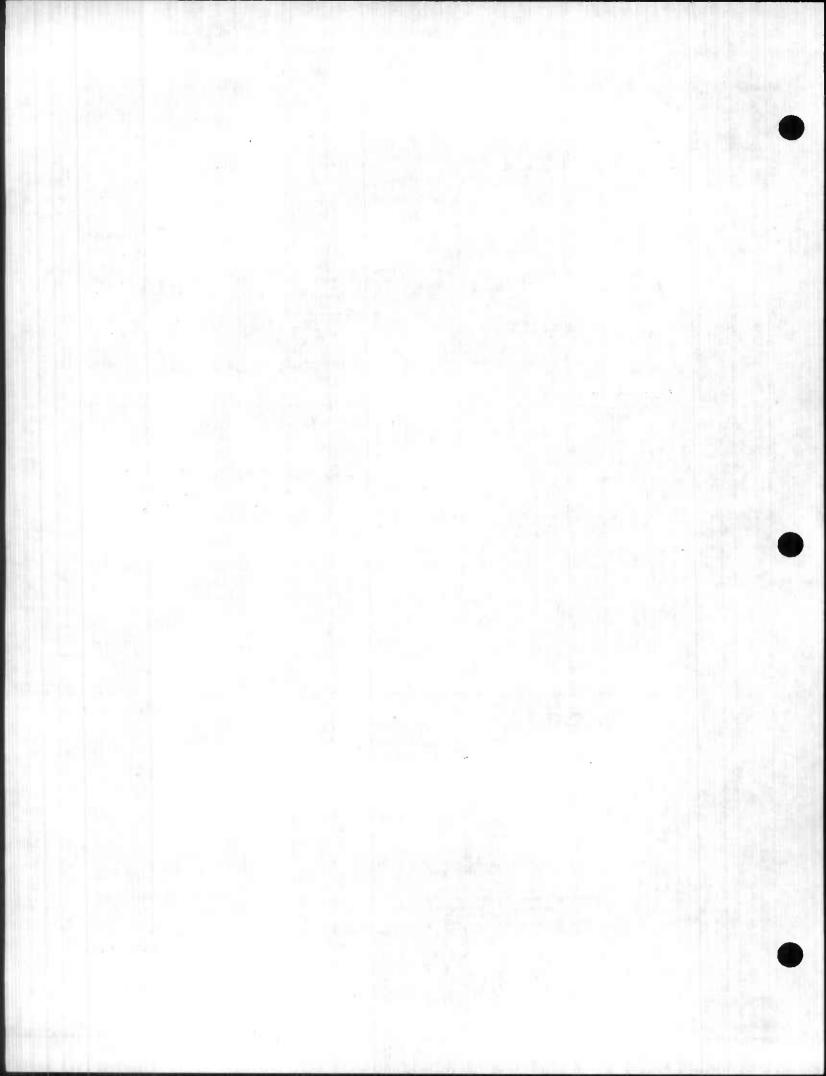
29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end address of person who completed cause of beath (Item 23a) (Type, Print)

31. Date filed (Month, Day,

ORIGINAL



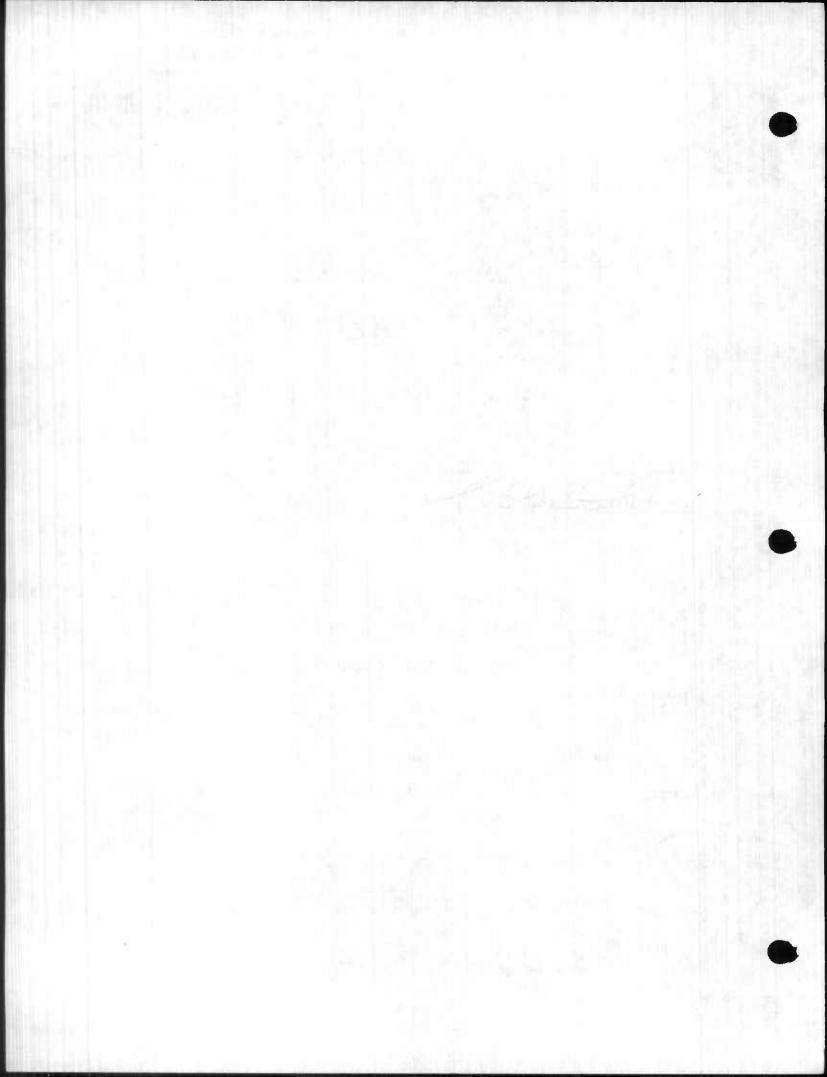
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1 4 2 0 9 9

			Certificate of	of Death	Re	g. No.	42099		
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Physician /Medical	CAMILLA	ULLSPERGER		I	ECEMBER				
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	Saint Joseph M			ltimore					
uneral	5. Social Security Number 6. Sec		Months Da		8. Data of Birth (Month, Dey,	Year) 9.	Birthplace (State or Fore Country)		
irector	213-30-7696	100			Nov. 23,	1900	Md.		
	Usual Residence of Decedent								
T det	10a. State 10b. County	Toc. City,	Town or Location				10d. Inside City Lim		
r 28a-f show	Md. Baltimor	e Tim	nonium						
or 2	10e. Street and Number		10f. Zip Cod	e	10	og. Citizen of Whe	t Country?		
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od out	17. Father's Name (First, Middle, Last)			18. Mother's Nen	ne (First, Middle, A	Aaiden Surneme)			
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7 is marke treumatic TO	19e. Informent's Neme/Reletionship (Ty	pe, Print)	19b. Mailing Address (Str	reet and Number or Ru	ral Route Number,	City or Town, Sta	te, Zip Code)		
200	John F. Ullsperger,	M.D./son	1704 Pot Spi	ring Rd.	Timonium,	Md. 210	93		
Item 2 other	20a. Method of Disposition	CON	ce of Disposition (Neme or netery, crematory or other	plece)	Dete	20c. Location - Cit	y or Town, State		
important: if its any injury or ot once.	1 ☐ Burlel 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emovel from State	Ltop Service		12/29/00	Timoni	um. Md.		
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burial-trens	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury		DAYS						
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as b		/	of death?						
page Page					1 □ Ya	s 200No	1 ☐ Yes 2 No		
certificate rector, page Be Co	25. Was case referred to medicet			26. Piece of De	eth (Check only on	e)	7-3-		
	examiner? 1 Yes 2 No	lospitel: 1 Inpatient 2 El	R/Outpatient 3□ DOA	Other: 4 Nursing H	Iome 5 Reside	ence 6 Other	(Specify)		
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Direct d in by	4 Homicide	City or Towr	i, Stata)						
To the Funeral completely filled	29a. Certifier 12 Certifying Phys	iclan: To the best of my knowle	edge, deeth occurred et th	e time, date end plece	, end due to the ce	euse(s) end menn	er es stated.		
Completely filled Medical Ce		ner: On the basis of examinetio and manner stated.							
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)	30. Nama and address of person who co			a g green ought jobb, b 2 jobb, and	h 1	LONIN CO	CONTRACTOR ACTION ACTIO		
	LILIA CEBALLOS,		OSLER DRI	VE TOWSO	N, MHRY	LAND 21	C1/214		
State	31. Dete filed (Month, Dey, Year)	32. Registrar's Signatur	ra & Kon	E					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Tima of Death Month Day Carolyn Whitaker 28, Dec. 2000 10:10am 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore
| If Under 24 Hrs. | 8. |
| Hours | Min. | Union Memorial Hospital If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 10 M &CXF 57 216-42-6108 VA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No X X MD Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1920 East 31st. Street 21218 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Bleck, White, etc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Assembler General Motor High School 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Charles Н. Reid Thelma M. Johnson 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rochelle Garland 3122 Lawnview Avenue Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) MD King Mem. Pk. Cemetery 01-03-01 Randallstown, 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Baltimore, Maryland 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiretory errest, shock, or heart feilura. List only one causa on each line. WM.C.March FH 1101 E. North Avenue Approximata Interval Between Onset and Death Myocardial Infarction Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of): pertension Sequentially list conditions, if eny, leeding to immadiata cause. Enter Underlying Cause (Disease or injury Due to for es a consequença of): percholestrolemia that initiated events resulting in death) Last Dua to (or as a consequenca of): ascular Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes 2 Tho 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner-of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner physician and the buriai-fransit the death certificate be executed attending pl by the a signed b should certificate has b lirector, page 2 s this funeral After or Attanding r death. the after death Director: in by

Physician

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Pages 1 and 2 should be filed within 72 hours after death nent of Heath and Mental Hygiene.
mt: if item 27 in marked other than "natural", or flema 23 mry or other traumatic event, the Heate Exertine many or other traumatic event, the Heate Exertine man

permit. Page Department of Important: If any Injury or

Physician

/Medical

Examiner

Physician/Medical

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Completed

Be

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Certification:

edical

4 THomicide

29b. Signature and title of certifier

29e. Certifier (Check only one)

Baltimore,

the Maryland r 28a-f ahow

With

Box 68760. Division of Vital Records. To the Hospital of within 24 hours a To the Funeral C completely filled Hospital

> State Registrar

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and mannar stated. 29d. Date signed (Month, Day, Year)

DYINGHHH

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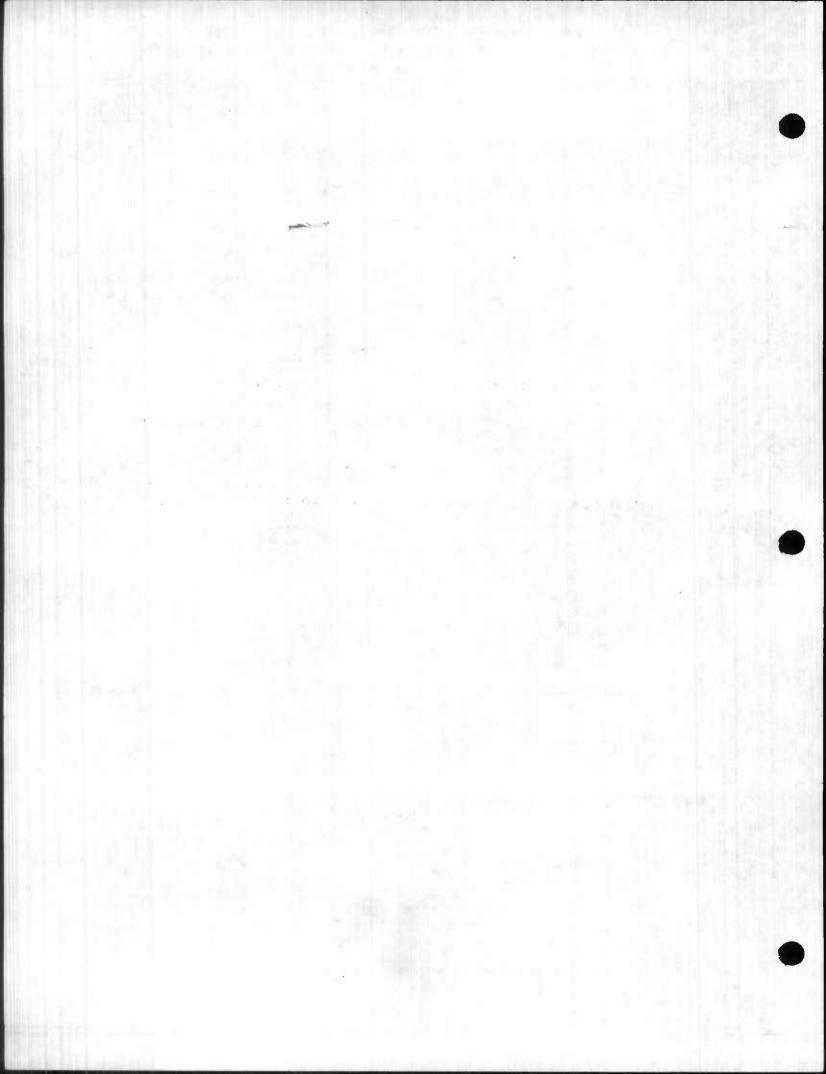
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2323 Orleans Street

Koval Medical Center

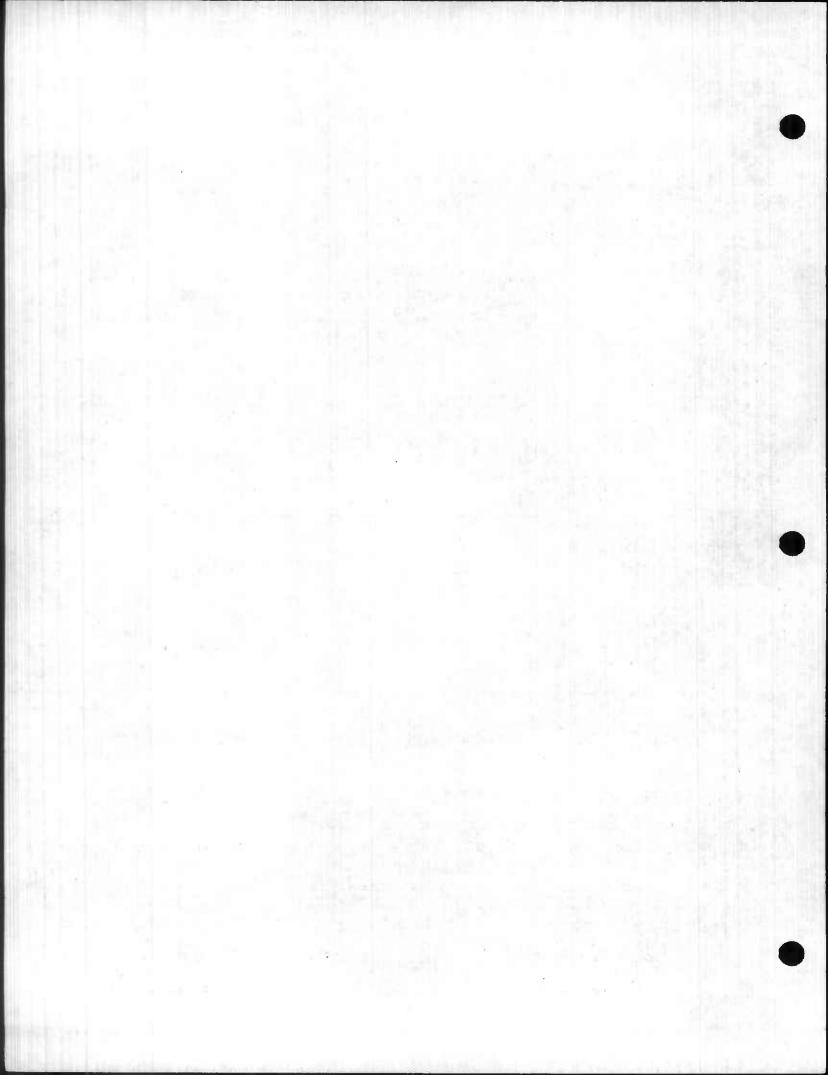
Dr. Nina Everett, MD_Matilda 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL



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	die death	by Funer	267 Stanmore] 11. Marital Status 1 Never Married 2		12. Was Dece Armed Fo		S. 21212 13. Was Decedant of Hispanic Origin? (Specify Yas or If Yas, specify Cuban, Maxicen, Puerto Rican, atc.)						No- 14. Race - American Indian, Black, Whita, etc.				
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or of its		1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Othar (Specify) State Cramatory or other place) Metro Crematory Inc. 12-30-00 Balti										ltimor					
Bal	Baltin permit. Per Department Important any injury		21. Signature of Fonaral Sarvice Licenaee 22. Name and Addrass of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD														
	Physician /Medical Examiner	er	23a. Part1. Entar tha diseas shock, or heart failura. Immediate Cause (Final disease or condition resulting in death)	-	lications that c na causa on a a.	Mu	h. Do not an	ar tha mode	a of dy	ing, such as	cardiac	or raspiratory	arrest,	e, MD	tnt	AO proximata arval Batween asat and Death	
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Division of Vita Hours or Attending Physician: Affour after death. Function Director: After this certific pletty, and in by the funeral director.	Certification: To	3 Suicida 6 □ Co		28a. Data /2/2		ER/Outpatie 28b. Tima o Injury (900 ome, farm, st	f 2	28c. Inju	ury at ork?			frav.	Stream Number of	1664	vetice outa Number, outs M		
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<	Sta	ate	30. Name and addrass of pe J. Afov 31. Data filed (Month, Day,)	604	EIM	a of daath (Iten		111 1			æt,	Baltim	ore,	Maryl	and	21201	
Dill	Regist		JAM	3 200	1 /	Layer	10	pp	on	23							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death **Physician** 31. 2000 **ICEODEANE** WAGNER December 1:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pickersgill, Inc. Towson Baltimore 8. Dete of Birth (Month, Day, Year) Sep. 28, 1897 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F Days Hours 060-07-3096 103 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 🖾 No Director Md. Baltimore Towson 10s. Street end Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Ave. 21204 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Detas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 X Never Merried 2 Merried 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Advertising 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 80 is marked of Jacob Wagner Lavinia 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 at Department of Health and Important: If Item 27 is m Pickersgill, Inc./care giver 615 Chestnut Ave. Towson, Md. 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park 01/04/01 Baltimore, Md. 22. Name end Address of Fecility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Betw Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner attending physicien and for use es the burfal-transit certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated evants resulting in death) Lest Due to (or as e consequenca of): Dua to (or as a consequence of): 98 The law requires that the death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yss 2 No 3 ☐ Probably 4 ☐ Unknown þ should | 24a. Wes en eutopsy 24b. Were eutopsy findings available prior to completion of cause of death? Completed page 2 s 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Horna 5 Residence 6 Other (Specify) 1 Yes 2 No To 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending invastigation 1 X Natural 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a Certifier 1/2 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. edicai 29d. Data signed (Month, Day, Year) 29b. Signature and little of gertifier 29c. Licansa number ung

Division of Vital Records,

Saltimore, Maryland 21215-0036

Registrar

31. Dete filed (Month, Day, Year) JAN

30. Neme end address of person who completed

32. Registrer's Signeture

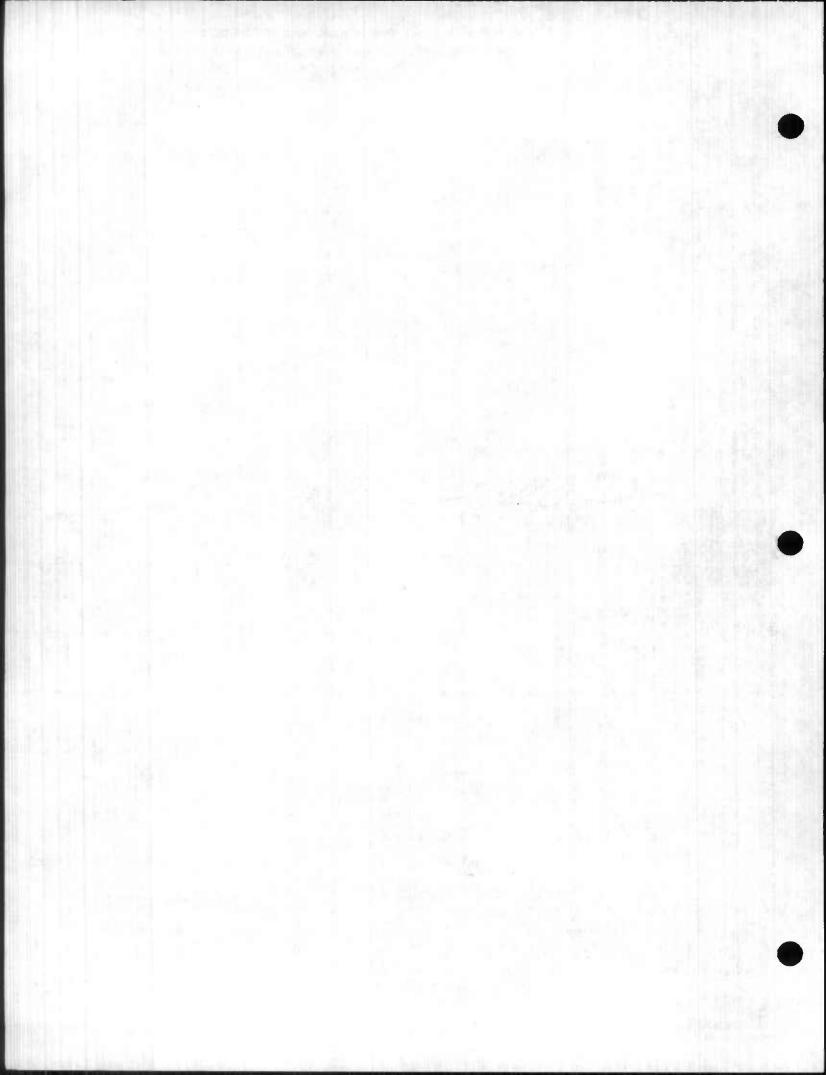
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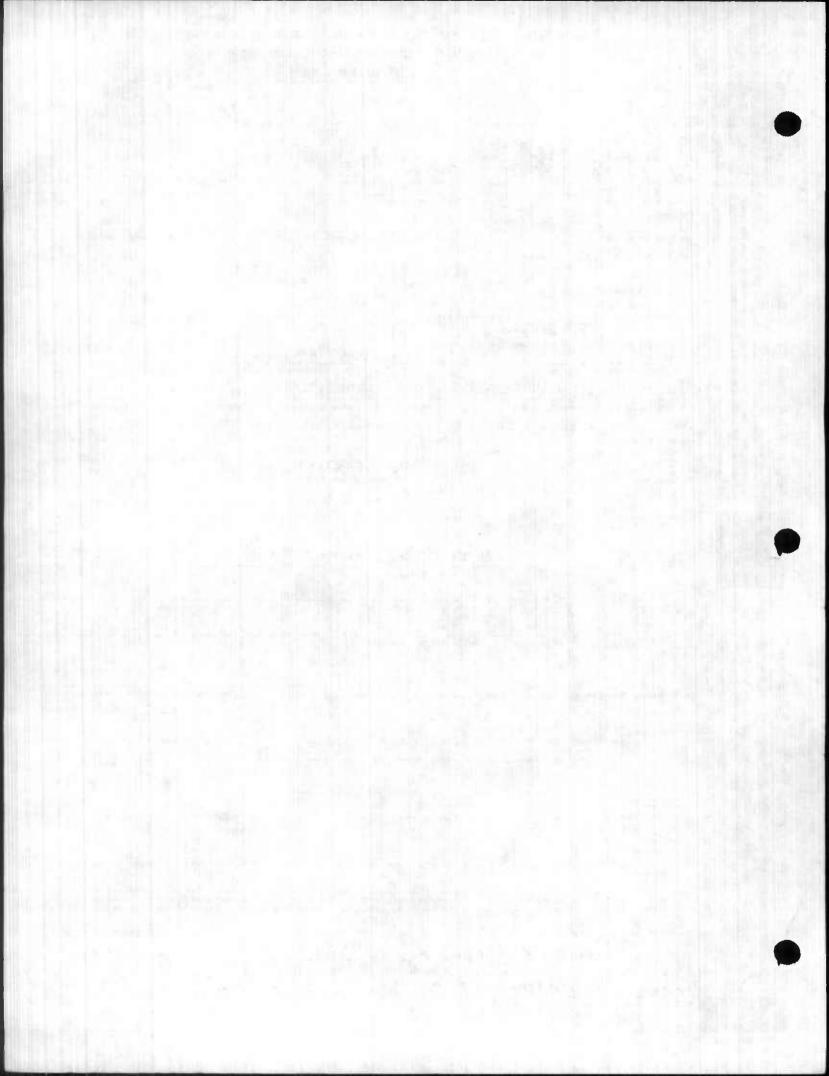
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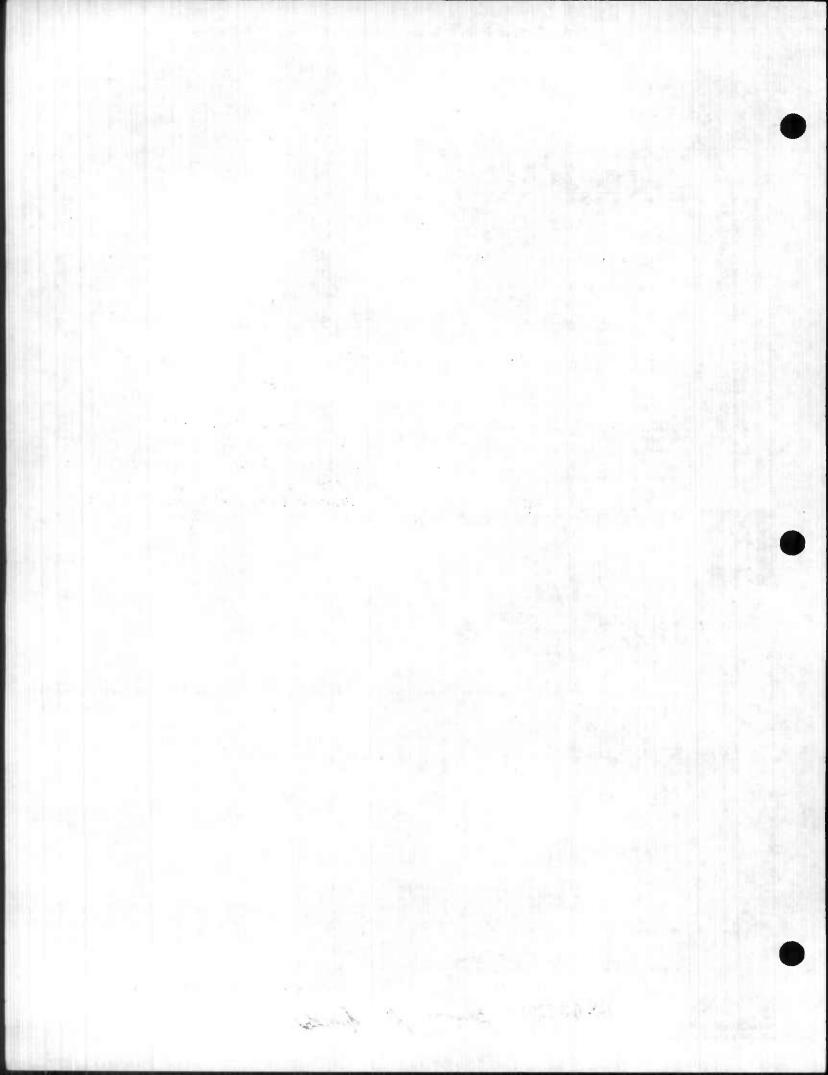


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland	Certificate			eg. No.	42103			
Physician /Medical Examiner	LOUGLASS	FRANK (WITTS'	TRUCK 4b. City, Town, or BALTIMO		Dey Year 30 200 4c. County of De	eth 0 30 AM			
Funeral Director	5. Social Security Number 230-22-9306 Usual Residence of Decedent	7. Age (In yrs. le	3 Yrs. If Under 1	Year If Under 24 Hrs Deys Hours Min.	8. Defe of Birth (Month, Dey,	Year) 9.8	irthplace (State or Foreign Country) ARY LAND			
with the Meryland a cr 28a-f show	10a. State 10b. County	1	Town or Location ALTIMORE				10d. Inside City Limits 1 ☐ Yes 2 ☒ No			
5 8 3	10e. Street and Number 8523 DRUMWOOD	ROAD	10f. Zip C	21234			TES OF AMERICA			
O20	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ⊉Yes 2 □ No If Yes, Give Yeer or Detes:		nt of Hispenic Origin? (S y Cuben, Mexicen, Puer ☑ No Specify:	pecity Yes or No- to Ricen, etc.)	14. Race - An Black, Wh Specify: (L				
2121 I within liene.	15. Decedent's Edu (Specify only highest grad		life. DO NOT use	done during most of wo	rking	16b. Kind of Business/Industry FEDERAL GOVERNMENT				
ges 1 and 2 should be filed to Health and Mentel Hygi if them 27 is marked other or other treumatic event.	17. Fether's Neme (First, Middle, Last)	WITTSTRUCK			18. Mother's Neme (First, Middle, Maiden Sumeme) ORA EVELYN TYLER					
Magazine Strie	19e. Informant's Neme/Reletionship (Ty MRS. DAWN SAUERW	/	19b. Mailing Address (Street and Number or RI	^	~ ^	, Zip Code) ND 21234			
Baltimore, permit. Peges 1 et Depertment of Hea Important: If Nem: any Injury or other and Imperent.	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	lemovel from State	ece of Disposition (Name metery, cremetory or oth RKWOOD CEI	er place)		BALTIMORE	or Town, State , MARYLAND			
Baltimo	21. Signeture of Funeral Service Land	hum		Address of Fecility 2G FUNERAL HO	ome, P.A. 6	009 HARFO	ED ROAD MARYLAND 21214			
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Offe	FRANCIS X. CA	EMODY, M.	D. 75056	SLER DR	·#212 /	OWSON, 1	n). 2604			
State Registrar	31. Dete filed (Month, Dey, Year)	32. Registrer's Signet	ure & And	e Ka						



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Funeral	5. 5	Social Security Number 6.		Aga (In yrs. last	birthday) If Under			8. Data of Birth	Vone	9. Birthple	ace (Stata or For
Director	2	15-78-5205	1€ 2□ F	41	Yrs. Months	Days	Hours Min.	(Month, Day,			. D .
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how #	10e	e. Stata 10b. County		10c. City, To	wn or Location					10	d. Inside City Li
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	Examir	_								wn, or Location of Deetl		ty of Death		
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П	Funeral Director		5. Social Security N 227-44-66	599	Sex 1□M 2XF	7. Aga (In 88	yrs. last birthd Yrs	Months [Yeer If Undar 2 Days Hours	8. Data of Bir (Month, De July 28	th y, Year) ,1912	9. Birthp Cour Indi	place (State or Foreign etry) ana	
	D	-	Usuel Rasidence of 10a. Stata	10b. County		100	c. City, Town o	r Location				1	Od. Inside City Limits	
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	28	Funeral Director	10e. Street and Nur		Lunacı		Cano	10f. Zip C	oda		10g. Citizen of	What Cour	ntry?	
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	thems 2	ner	11. Marital Status 12. Was Decedant Evar in U.S. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-									ce - Americ	can Indien,	
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	4 10 2		Robert B.		/ Son					d, Gambrill		21054		
ore			20a. Method of Disp 1 Novial 2		☐Ramoval from		cematery,	sposition (Nama crematory or other	er plece)	Data	20c. Location	- City or To	wn, Stata	
E .	Baltimore, pemii. Pages 1 ar Department of Hee Important: if Nem 2 any Injury or other page.		4 Donation	5 Othar (Spe	cify)	H	lillcre	st Cemet			Annapol	lis, M	Maryland	
3al			21. Signature of Fu	neral Service to	HINSOE V)			Address of Facility	al Home, P.	Α.			
-			Ch	Val	510	M	e 1	12 Ridg	jely Ave	nue, Annapo	lis, Ma	arylar		
			23a. PartT. Eftar ti shock, or haa	ne diseasa, of de rt failura. List de	emplications that only one cause on a	ausad tha ach lina.	death. Do not	antar tha moda	of dying, such as	cardiac or raspiratory a	rrast,	1	Approximata Interval Between Onset and Death	
	Physician /Medical Examiner		Immediata Cause (Finel disaasa or condition rasulting in death) a. ACUTE RENAL FAILURE										3DAYS	
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>	die die	TOE	axaminar? 1 ☐ Yes 2 🗷	No	Hospital:	Inpatient	2 ER/Outpa	itient 3 DOA	Other: 4 Nu	rsing Homa 5 Rasi	dence 6 🗆 O	thar (Speci	(y)	
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	within :	N	29b. Signatura and	titla of certifiar				29c. l	icansa number		29d. Date sign			
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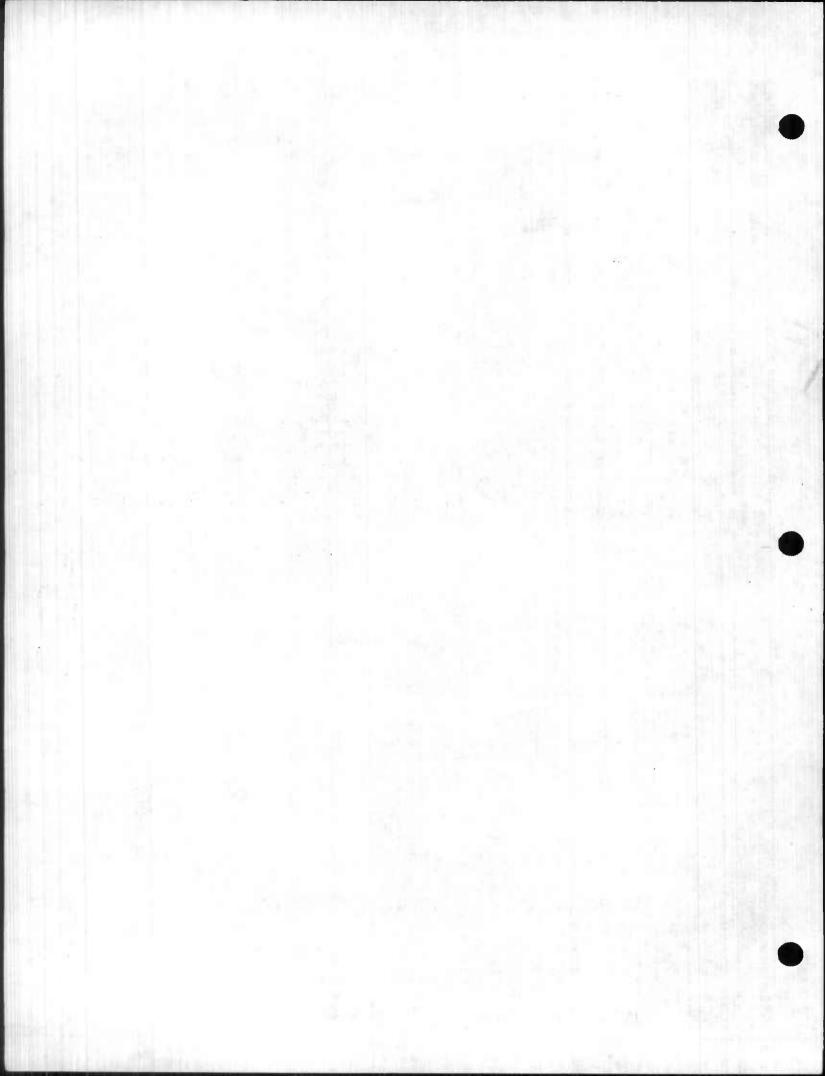
State Registrar 31. Data filed (Month, Day, Year)

JAN 0 3 2001

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Sparks

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 1150 am WEBER December 30 2000 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Hospital Baltimore Agnes n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Days 1₩ 2□ F 215-14-9161 79 Yrs. 09-21-1921 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Pasadena 10e Street and Number 10f. Zio Code 10g, Citizen of What Country? 461 New York Avenue 21122 USA 12. Was Decedent Ever In U,S. Armed Forces? ↑♥) Yes 2 □ No WW 2 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Caucasian 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Structural Engineer BG & E 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John C. Weber Freda Voelker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Elaine Weber P.O. Box 72369, Baltimore, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn 01-04-01 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. Acres Management 1201 Dundalk Avenue, Baltimore, MD 21222 23a. Parl 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) prascular Due to (or as a consequence of) wormsonath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for 4s a consequence of): Heart Failure Ungestive Due to (or es a consequence of) Pulniman Obstructive Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown nothyrodish, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1□Yes 2□No 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

attending physicien end for use as the burial-transit certificate be executed Ses The law requires that the death ed by the a signed by peen s is certificate has I Hospital or Attending Physician: this After this funeral I Director: A To the Hospital
within 24 hours a
To the Funeral C

Physician

/Medical

Examiner

Funeral

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Physician

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Physician/Medical

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Certification:

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29a. Certifier

(Check only one)

/Medical

Baltimore, Maryland 21215-0036

MD Director

by

Completed

Be

NAME Webel, John

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rurel Route Number, City or Town, Stete)

12/30/00

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

AS 2 43 8528-3

M-N 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

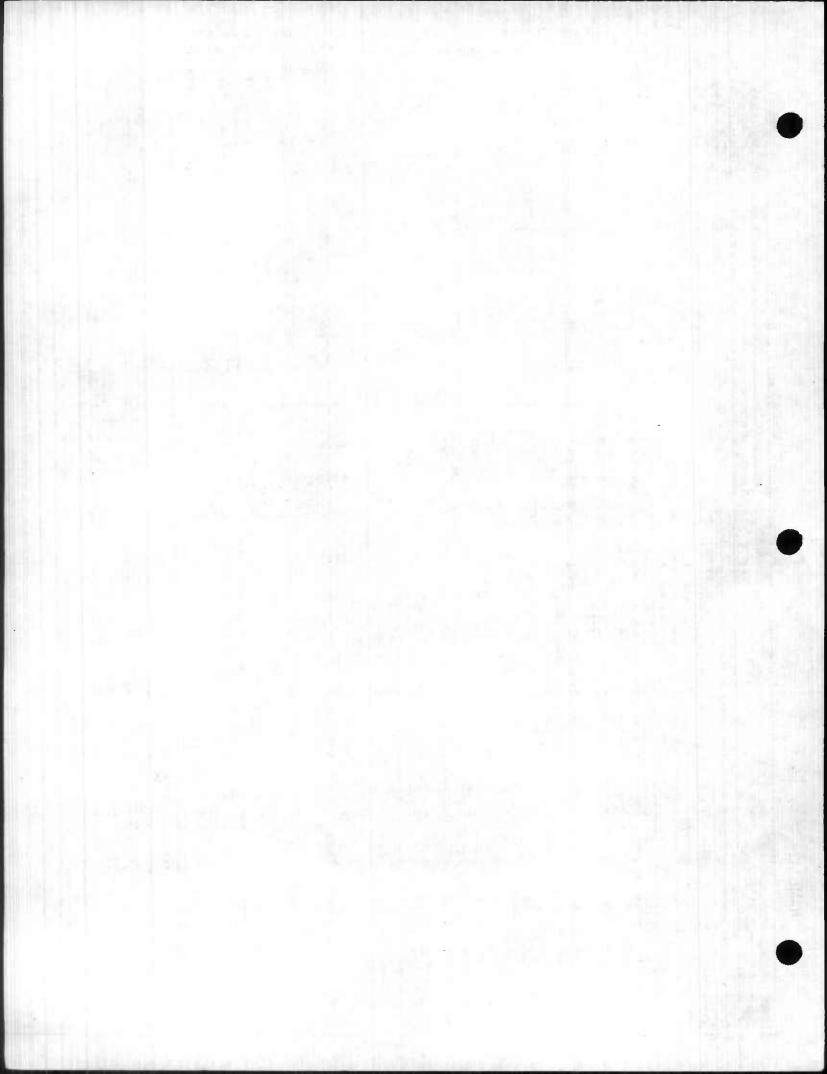
1222 TAYLOR LANE

BALTIMORE , MD, 21227

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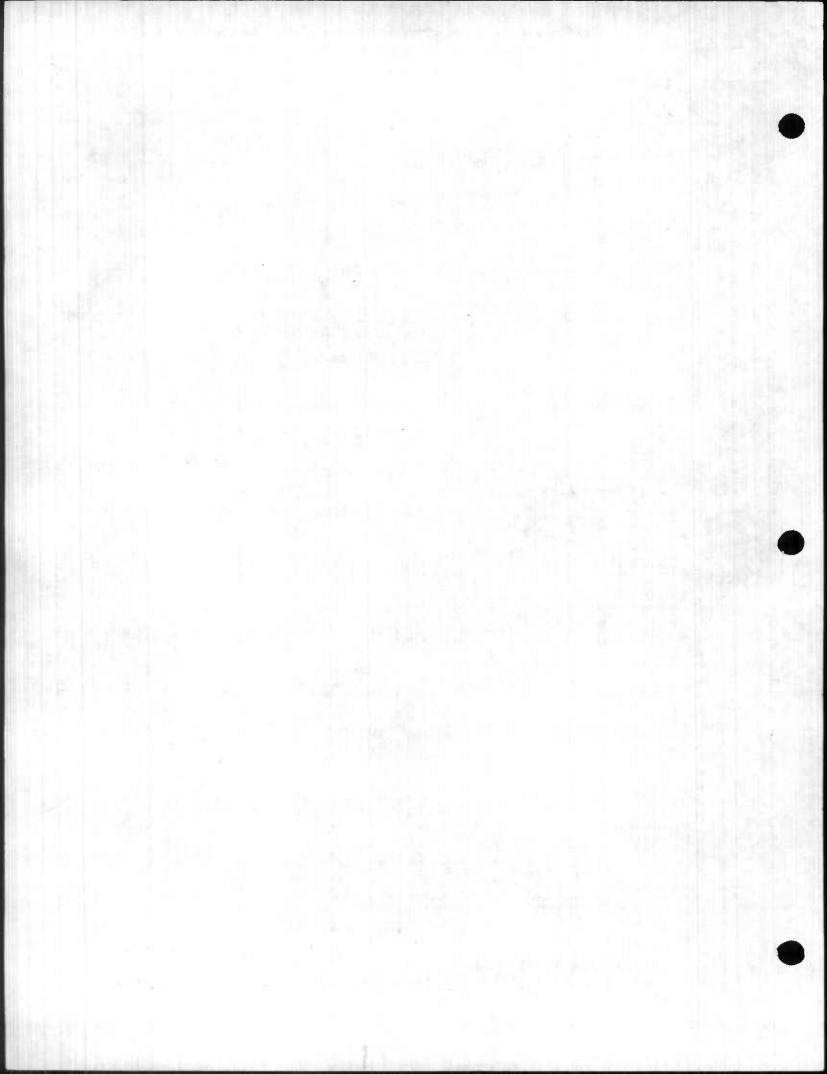
29b. Signature and title of certifie

32. Registrar's Signature and and Dark ORIGINAL



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 29, 2000 6:25 pm Wissman, Jr. William /Medical .Tohn 4b. City, Town, or Location of Deeth 4a Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner N/A Baltimore Stella Maris at Mercy If Under 1 Yeer If Under 24 Hrs. 8. Data of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 MM 2□ F Days Yrs. 75 Feb. 23,1925 Maryland Director 219-14-1093 Usuel Rasidence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any fujury or other traumatic event, tra Medical Exercises must be notified at once. 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Directo Maryland Anne Arundel Glen Burnie 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 174 Virginia Lane 21061 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 1 Yas 2 □ No Was Decedent of Hispenic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2 No Specify: If Yas, Giva Yaar or Datas: W.W.II p 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) 12 N/A Senior Service Tech. 17. Fethar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) AMelia Kaiser 10 John William Wissman, Sr. 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 7990 Foxwell Ct. Glen Burnie, Maryland 21061 Mark R. Wissman (Son) 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, Maryland Greenmount Crematory 1/3/01 22. Nama and Addrass of Facility
McCully-Polyniak Funeral Home, P.A. 21. Signature of Funaral Sarvice Licensaa 237 E. Patapsco Ave Baltimore, Maryland 21225 23a. Part1. Entar ne diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or reart tailure. List only one cause on each line. Approximata Intervel Batween Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in daath) bludder /Medical Stron Examiner Dua to (or as a consequence of): Physician/Medical Examiner the death certificate be axecuted physician and the burial-transit Sequentially list conditions, if any, laading to immediata cause. Entar Undarfying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequanca of): Division of Vital Records, P.O. Box 68760, Dua to (or as e consequance of): attending pt for use as t signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably þ should I 24a. Wes an autopsy performed? 24b. Wara autopsy tindings available prior to Completed completion of ceuse of death? certificate has b 1 🗆 Yas 1 Yas 2 No 25. Was casa ratarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Dothar (Specify) No Spill 1 Yas 2 No 2 After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Dascribe how injury occurred Certification: or Attanding 1 Ø Natural 2 ☐ Accidant 5 Panding invastigation s after das. 1 Yas 2 No 6 ☐ Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, tarm, street, tactory, office building, atc. (Specify) 4 Homicida Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. edical 29a. Certifiar To the Hosp within 24 hou To the Fune (Check only one) 29d. Data sighed (Month, Day, Year) 29b. Signatura and titla of certifia 29c. Licansa number 40854 12/29/ 2000 M Parl Pl Bultmore 30. Name and address of person who complated ceusa of deeth (Item 23a) (Type, Print) St cusibu 301 31. Data filed (Month, Day, Year) 32. Registrar's Signetura State JAN 0 3 2001 Registrar

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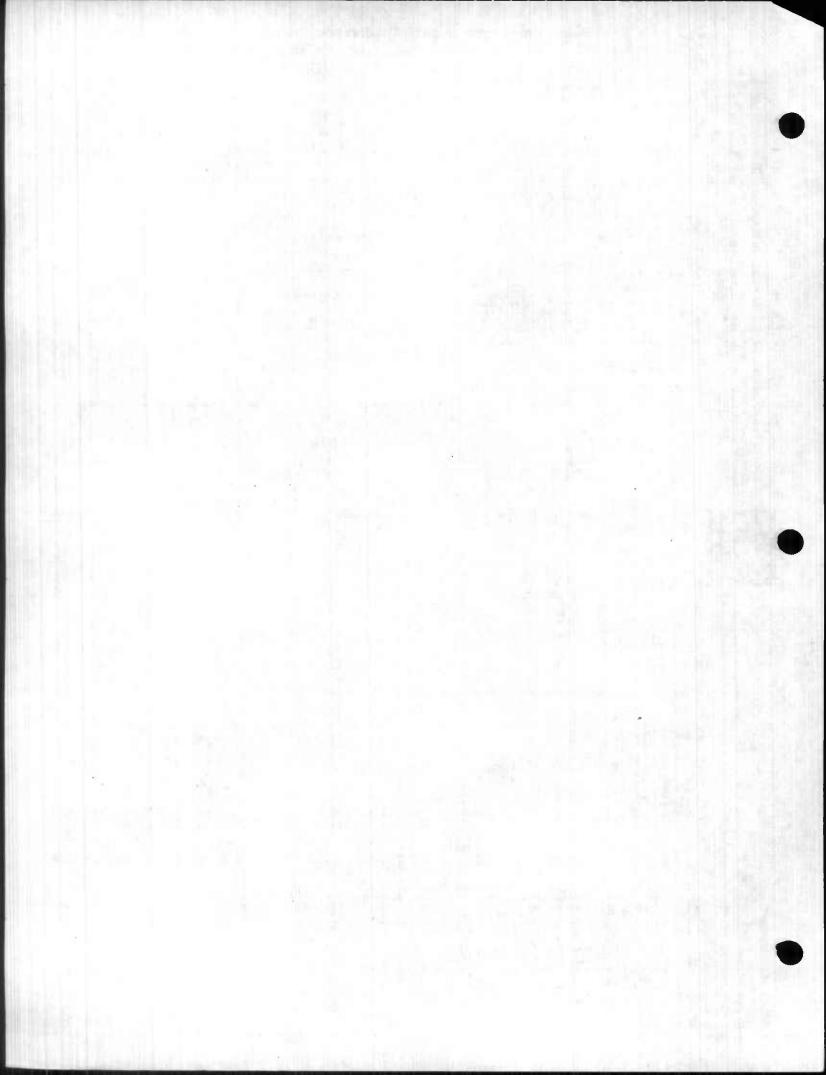
J-7363-027 DERRICK WALKER

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23a,27 pe	er me G791 1/9/01 y			Cei	tificate of	Death	2. Data of De	Reg. No.		3. Tima of Death
Physician /Medical	Derrick D. Wa							BER 21,	2000	05:15 A.
xaminer	4e Fecility Name (# not institute 7201 ASSAT					4b. City, Town, or I	ocation of Deat	th 4c. County		FIG. 18
al .	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth		laca (Stata or Foraign
	458-49-4575	1 M 2 F	30	Yrs.	Months Days	Hours Min.	3/28/1	970"	MS	(try)
	Usual Residence of Decedent 10a. Steta 10b. Cour	у	10c. Cit	y, Town or Lo	cation				10	0d. Inside City Limits
	AR Pul	aski	Jac	cksonv	ille					1 ☐ Yas 2 ☐ No
ı	10e. Street end Number	THE ANSA			10f. Zip Coda			10g. Citizan of	What Coun	try?
-	209 Turkey Tr		and an Francis II	0 40 1	72076	liancia Origina (C	nasit. Van as bl	USA	ea - Amaric	an Indian
	11. Marital Status 1 Nevar Married 2 M 3 Widowed 4 Divorce	Armed F	2 No		Yes, specify Cub	Hispanic Origin? (S an, Maxican, Puart Specify:	o Rican, atc.)		ck, White,	atc.
-	15. Deced	int's Education ast grada completed	0	(Giva	lent's Usuel Occup	during most of wor	16b. Kind of B	usiness/Ind	dustry	
	Elementery/Secondary (0-12	(2) College (1-4or 5+) Truck Driver Tru							no	
	17. Father's Neme (First, Midd	, Last)		Truci	DIIVEL	18. Mothar's Nan	na (First, Middle			
	Leroy Walker		1			Bobbie				
	19e. Informent's Name/Ralation Leroy Walker	nship <i>(Type, Print)</i> Fathe	r	1 - 1 - 1 - 1 - 1		and Number or Ru				
	20a. Method of Disposition	rathe	20b. F	Place of Dispo	sition (Nama of		Data	20c. Location		
	1 Burial 2 Crematio		n State	amatary, cren	na <i>tory or othar pl</i> a 1 Mem. Pa	1,	12/27	N. Litt		
	21. Signetura of Funerel Sania		/)	22	. Name end Addre	ess of Facility				
	1 Tolunt	Varlac	12			Ashton-Sc dson Ave				Inc.
Examiner	tmmediata Causa (Final disease or condition resulting in deeth)	8	DIABETI(C KETOAC						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that i	b	Dua to (o	r as e conseq	uenca of):			- 120		
	Cause (Disaasa or injury that initieted events rasulting in daath) Last	c	Dua to (o	r as a conseq	uanca of):					
	Pert II. Other significant condi	lons contributing to	death but not ras	ulting in tha u	nderlying cause gi	van in Part I.	· 23b. Did	tobacco use co	ontribute to	the cause of death
							1 🗆	Yes 2□No	3 □ Prol	bably 4 Unknow
						77.14-3		s en autopsy ormed?	ev	ere autopsy findings eilabla prior to mplation of cause death?
							N	Yas 2□No	10	Ŷes 2□No
-	25. Was casa ratarred to medi axaminar?	-				26. Placa of Dec	ath (Check only	ona)		,
	1 Yes 2 No 27. Mannar of Death			ER/Outpatier	T 3LI DOA			idance 6 Dot		y) SCENE
	1 Natural 5 ☐ Pen 2 ☐ Accident inva	tigetion	e of Injury onth, Day Year)	tnjury	Wo	rk?] Yas 2 □ No				
	3 Suicide 6 Cou	mined 28a. Plac buik	ca of Injury - At he ding, atc. (Specif	oma, farm, str y)	eet, factory, office			(Street and Num own, Stata)	ber or Rure	al Routa Number,
		ing Physician: To the Examiner: On the and me								
	29b. Signature and atte of certi				29c. Lican			29d. Data sign	-	
	1/6	topeu	ue)		0.0	C.M.E.		DECEME	ER ZI	.,2000
	30. Nama and addrass of pers	n who complated cau	asa of death (Item			most De	1+i	Massala	nd 21	201
	31. Data tiled (Month, Dey, Yea	10	Registrar's Signa		rem 50	reet, Ba	спюте	, MOLLY LC	uki Zl	201

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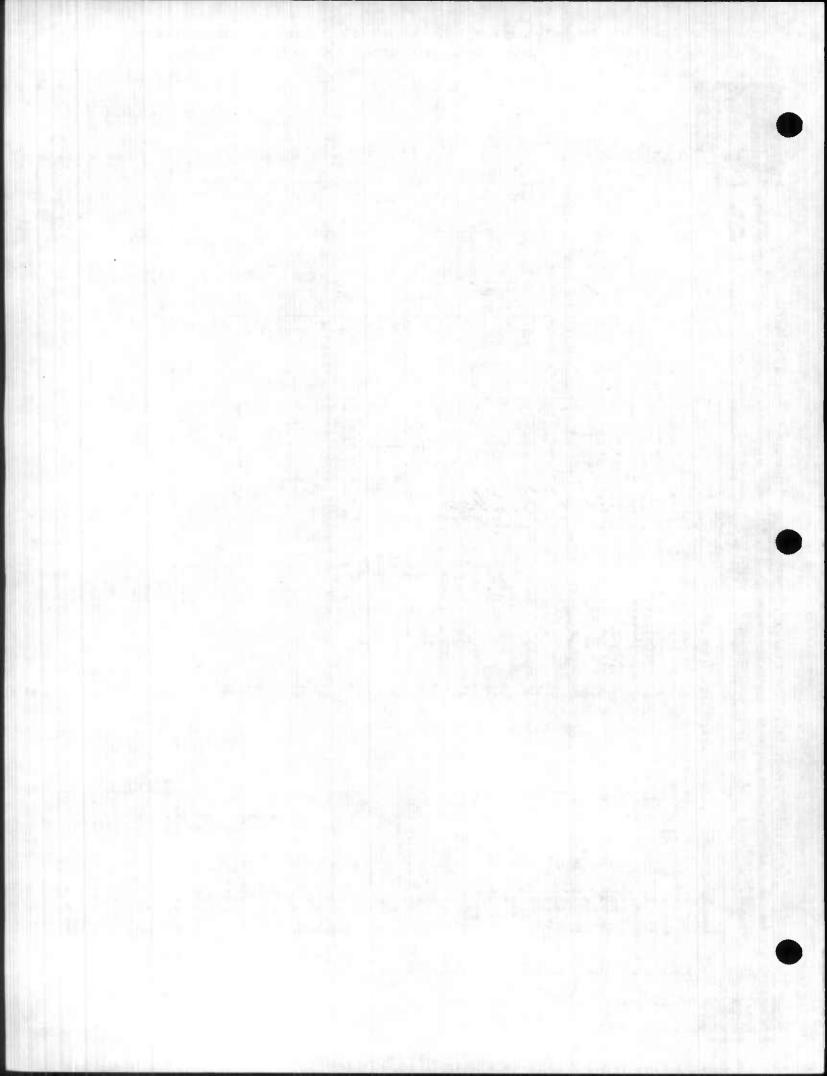
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State of Maryland / Department of Health and Mental Hygiene

			Certificate of L	Death F	leg. No.	2110
	Dhuminian	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year	3. Time of Death
	Physician /Medical	Dorothy walt		Decem	ber, 29, 2000	4:12AM
	Examiner	4a Facility Name (If not institution, give street and number)	4	b. City, Town, or Location of Death	4c. County of Death	f 1
		Mercy Hospital		saltimore	Baltimor	e City
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In 215–32–5536 1 M 215 64	yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Birth (Month, Dey 04/22/1		nplaca (State or Foreign intry) land
	P 2		c. City, Town or Location			10d. Inside City Limits
	Many tash	Maryland N/A	Baltimore			1 Nes 2 No
	off the Maryla to 28s-f show be notified at Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	untry?
	E # 13	603 S. Glover Street	21224		USA	
020	ours after deat rait, or flores: Examiner ma	11. Meritel Status 1 Never Married 2 Married Armed Forces? 1 Yes, Give Yeer or Dates:	r in U,S. 13. Was Decedent of Hir If Yes, specify Cubar	spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) Specify:	14. Raca - Ameri Black, White Specify: Whi	e, etc.
5-0	72. h	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupa	ition Juring most of working	16b. Kind of Business/Ir	ndustry
21215-0020	ygiene. ygiene. werthen *naturn it, the Medical.	Elementery/Secondary (0-12) College (1-4or 5+)	(Give kind of work done dife. DO NOT use retired) Homemaker		Domestic	
P	office of the C	17. Fether's Neme (First, Middle, Last)		18. Mother's Name (First, Middle,	Maiden Sumame)	
ılar	Mental H Mental H arked oth afte even	Marion J. Zych		Mary Szuchnicki		
Maryland	Short and a short	19a. Informent's Neme/Retationship (Type, Print)	19b. Mailing Address (Street a	and Number or Rural Route Numbe	r, City or Town, State, Z	ip Code)
2	27 th	Kenneth Walt / husband	603 S. Glover	Street Baltimo	re, Marylan	nd 21224
e e	1 He He	20a. Method of Disposition	Ob. Place of Disposition (Name of cemetery, crematory or other place		20c. Location - City or T	
Baltimore	Page ent c nt: If ry or	I Dunat 2 Incremation 3 I Hemover from State	Bayview Crematory		Baltimore,	Maryland
芸	anti.	21. Signature of Funeral Service Liganies	22. Name and Addres	s of Facility		rarytana
ä	age a	A . 1 (2 //		eber Funeral Hom		
-		23a Part 1 Enter the disease or complications that caused the	death Do not enter the mode of dving	ster Street Balt	imore, Mary	Approximete
W	Dhustaian	23a. Part1. Enter the disease of complications that caused the shock, or heart failure. List only one cause on each line.				Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	1500.			E X
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_6	icate be executed physician and s the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	to (or as a consequence of):			
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360				ALCO CALL		of death?
ie ie	certificate has rector, page 2			1 D Y	es 2 No 1	I ☐ Yes 2 No
VIE	certific sector	25. Was case referred to medical examiner?	20 EB/Outpations 20 DOA Othe	26. Place of Death (Check only or		
of	Physician: this certific ral director,	1 Tes 2 MrNo 1 Minpatient	ZLI ENVOUIDATION 3LI DON	4 Ituising nome 5 nesio	lenca 6 Other (Spec	ify)
5	After this funeral di	1 Meturel 5 ☐ Pending (Month, Day Ye		Yes 2 No	ow righty occurred	
2	Attending r death. ector: Afte by the fune	3 Suicide 6 Could not be 200 Bloom of Injury	At home, ferm, street, fectory, offica		Street and Number or Ru	ra I Route Number
Division of Vital	tal or Attending P rs efter death. at Director: After t led in by the funers Certification:	4 Homicide determined building, etc. (S	pecify)	City or Tow		
	portal portal filled	29a. Cartifier 1 Cartifying Physician: To the best of my	y knowledge, death occurred at the tim	ne date and place, and due to the	rausals) and manner as	steled
	To the Hospital or Attending Physician: The level filthin 24 hours effect death. To the Euroral Director: Affect this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	(Check only 2 Medical Examiner: On the best of examiner one)	mination and/or investigation, in my op	pinion, death occurred at the time, o	Jate and placa, and due	to the cause(s)
	Medic	29b. Signeture end title of certifier	29c. License	number	29d. Date signed (Month	n, Day, Year)
	12 m	R. 10 th	11 DI4			
	JW.	mar collin	1081.10.		deritor, o	.,,
~	7	30. Name end address of person who completed cause of death		667 D LPLACE, Bolto		1. 121202
		31. Dete filed (Month, Dey, Year) 32. Registrar's	Signature	- THILE, DOUTH	more, Mar	Jana 21 403
	State Registrar		wes A book	21		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 8 per informant G792 2/12/01 yf State of Maryland / Department of Health and Mental Hygiene Amended Item#17 perINFG791 1/8/2001 EW Certificate of Death Beg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death December 28,200012:25am **Physician** PRINCE B. WEBB /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A 4511 Norfolk Avenue (res.) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 06/25/10 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8 Sax 1912 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months Days Hours 216-07-4694 90 Yrs. Virgínia Director Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City. Town or Location 10d. fnside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at BALTIMORE 1 XYes 2 No MD Director N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4511 NORFOLK AVENUE 21216 U.S.A. o flied within 72 hours after death all Hygiene. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 20 No Specify Specify: Black P 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mobile Dinner Elementery/Secondery (0-12) College (1-4or 5+) Entrepreneur 7th permit. Pages 1 and 2 should be flie Department of Health end Mental Hy, Important: If Nem 27 Is marked othe any Injury or other traumatic event, pages. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Unknown William Webb Sarah G. Hockedy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4511 Norfolk Avenue, Balto., MD Elaine V. Webb 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Woodlawn Cemetery Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 01-03-01 21. Signature of Funeral, Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE BALTIMORE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) rostate menths Examiner Due to (or as a consequenca of) Physician/Medical Examiner attending physician and for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? the Part ff. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to should I 24a. Was an eutopsy performed? Completed completion of cause has 1 Yes 2 X No 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 Aesidence 8 ☐ Other (Specify) P 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attending To the Hospital or America After the Funeral Director: After the Funeral Director: After the fur 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

31. Date filed (Month, Day, Year) JAN 03

29b. Signature and/title of pertities

29a. Certifier (Check only one)

> 32. Registrar's Signature 5001

N. Chale St. Balto. md 2:20 x 6701

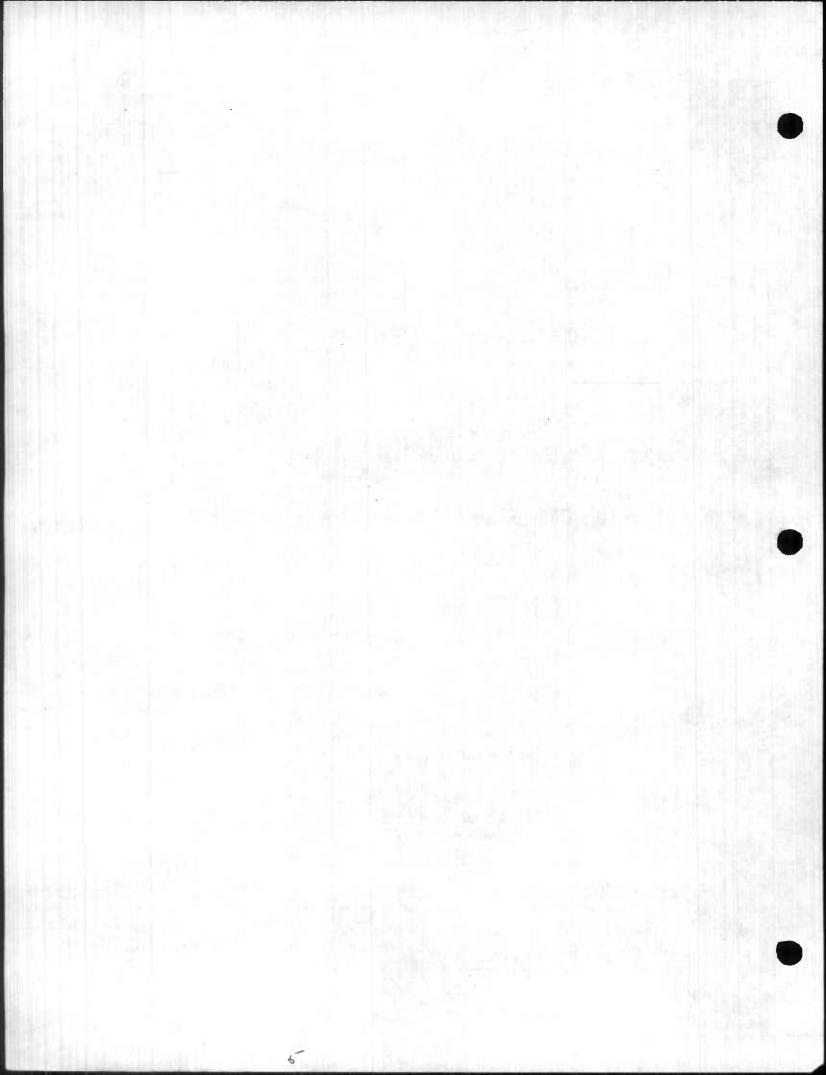
1 Certifying Physicfan: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner stated.

29c. License number

5200

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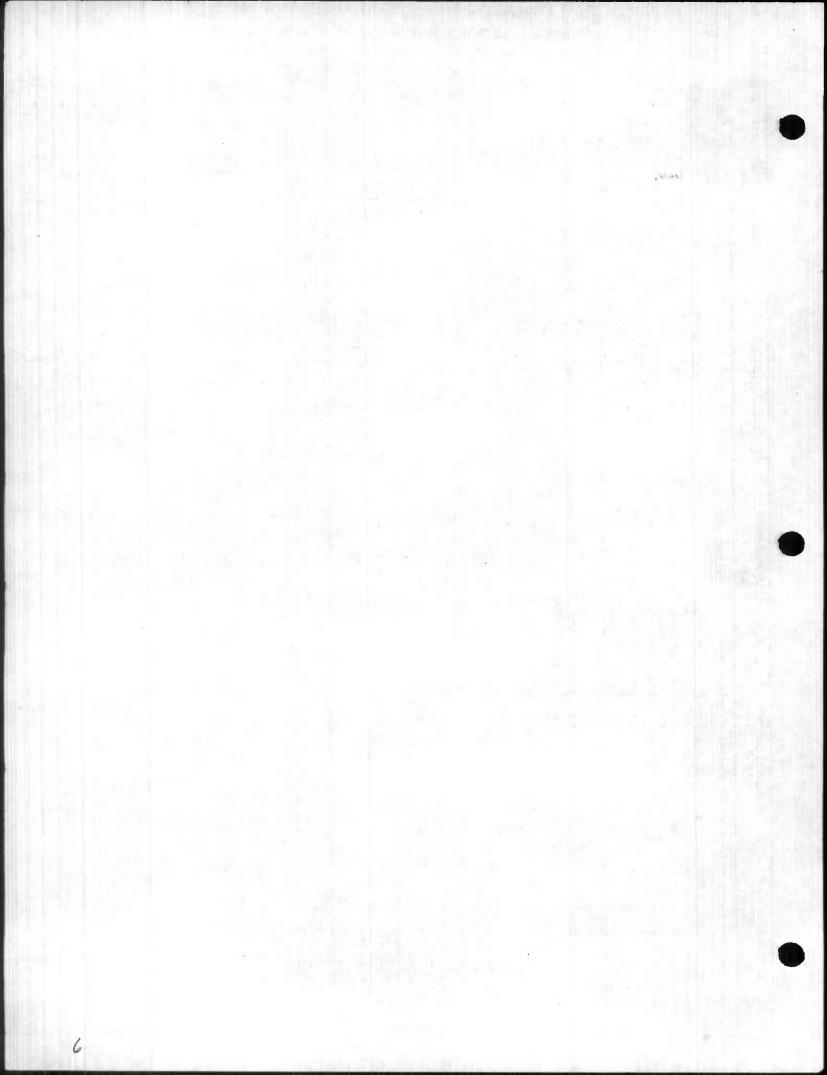
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State of Maryland / Department of Health and Mental Hygiene

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ineral	5. Social Security Num			. Aga (In yrs. les	t birthday)	If Under 1 Yas	ar If Unda	r 24 Hrs.	8. Data of Bi	th 3-19-30	Birthplace (Steta or Foreign Country)	
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Tol	David	William	ເຮ				J	osep	nine	Lancast	er	
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:uc	27. Manner of Death	☐ Pending	28a. Data of (Month,	Day Year) 2	8b. Tima of tnjury	28c. In			28d. Dascribe	how Injury occur	red	
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tiffe	3 ☐ Suicide 6	Could not be determined	28e. Piece of	f Injury - At hom , atc. (Specify)	e, ferm, stra	aat, factory, offic	:0			(Street and Numb wn, Stata)	per or Rural Routa Number,	
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edicai Certification:	29e. Certifier 1	Certifying Phys	sician: To the be	est of my knowle	edga, death	occurrad at the	tima, data a	and placa,	end due to the	cause(s) end ma	annar es stated.	
dic	(Check only 700 one)	Medical Exami	ner: On the basi end menna	Is of axamination	n and/or inv	astigation, in m	y opinion, da	ath occur	red at the tima	, data and place,	and dua to tha cause(s)	
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ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) DECEMBER 29 Month JOHN WEINBAK6 4b. City. Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) FEB. 9, 1917 Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. lest birthday) Deys 130-09-3369 83 Yrs. N.J. Usuei Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 XXVo BALTIMORE BALTIMORE 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 11 SLADE AVENUE #314 21208 U.S.A. 14. Rece - American Indian, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No 1 Never Merried 2 Married WHITE 1 Yas 2 No Specify: If Yes, Give Yaer or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N.Y. CITY SCHOOL SYSTEM CARPENTER 18. Mother's Name (First, Middle, Maiden Sumema) 17. Fathar's Nema (First, Middla, Last) MORRIS WEINBERG ROSE STARK 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 11 SLADE AVENUE #314 - BALTIMORE, MD 21208 SYLVIA WEINBERG / WIFE 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) GARDENS 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removat from State PUTNAM VALLEY, N.Y. 1/2/01 KING DAVID MEMORIAL 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Facility 21. Signeture of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, shock, or haart faitura. List only one ceuse on aech line. Approximete Intervet Between Onset end Death neumbers immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or as e consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco ues contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were eutopsy findings available prior to comptation of ceuse of death? 24a. Wes en eutopsy performed' 1 ☐ Yes 212 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Examiner

Physician/Medical

PV

Completed

Be

Certification:

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiel Important: If item 27 is marked other th eny injury or other traumatic event, the page.

Physician

/Medical

Examiner

Funeral

Director

r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

death

filed within 72 hours after

altimore, Maryland 21215-0020

Directo

Funeral

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Be

bunal-trar physician s the bunal as t usa Por signed by the a pega 2

certificate be execut

To the Hospital or Attanding Physicien: within 24 hours after death.

To the Funeral Director: Attar this certifica complataly

Division of Vital Records.

Registra

JAN 03 31. Dete filed (Month)

25. Wes case referred to medical examiner?

1 Yes 2 No

27. Menner of Death 1 Neturel

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

29b. Signeture end title of cerfifier

Hospital:

5 Pending investigation

6 Could not be

12 Inpatient

28a. Dete of Injury (Month, Day Year)

MI.

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. Licansa number

1 Yas 2 No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

- NWHE-

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dale end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the besis of axamination and/or invastigation, in my opinion, death occurred et the tima, data end place, and due to the causa(s) and menner stated. 29d. Date signed (Month, Dey, Year) ecoule 29, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

mpleted cause of death (ftem 23a) (Type, Print) 30. Neme and address of person was de

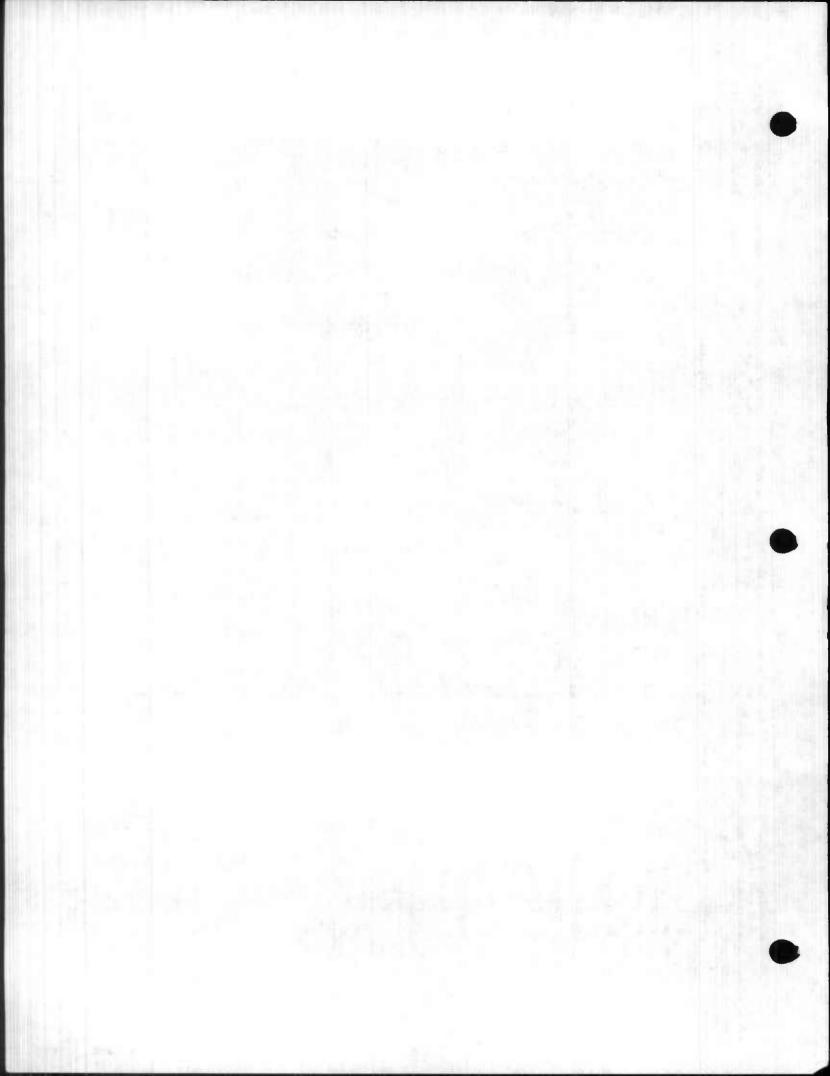
IMPERIN A.J

32. Registrer's Signeture

DHMH 16 Rev 6/95

2 ER/Outpatient 3 DOA

28b. Time of



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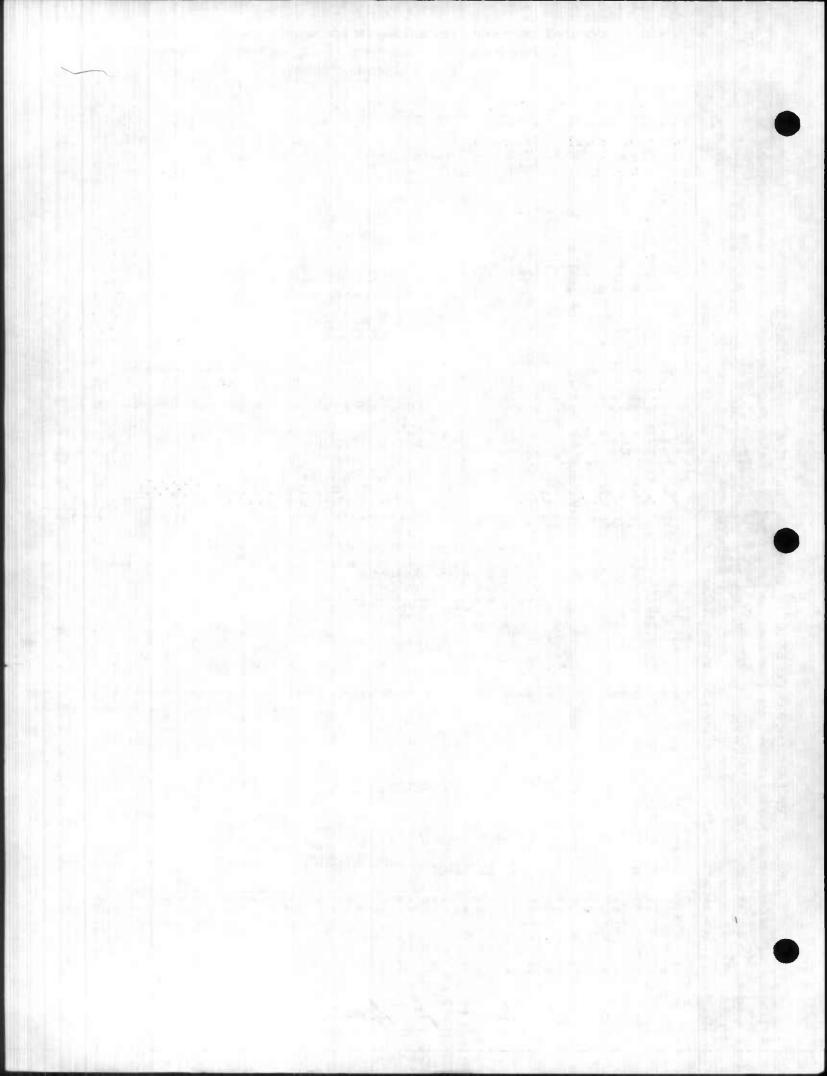
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Certificate of Death	Reg. No.		6	1	-

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/Medical Examiner	4e Fscility Neme (If not institution, gi	ve street and number)		4b. City, To	wn, or Location of Dea					
Examine.	STELLA MARIS	HOSPICE			TIMONIUM BALTIMORE					
[®] Funeral		Sex 7. Age (In yrs. last	birthdey) If Under 1 Months I	Year If Under Deys Hours	24 Hrs. 8. Date of Bi Min. (Month, D	rth av. Year)	Birthplece (State or Foreign Country)			
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har death v ritems 23s sizer must Funeral	11. Meritel Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Wes Deceder	nt of Hispenic Orl	t of Hispenic Origin? (Specify Yes or No- Cuben, Mexicen, Puerto Rican, etc.) 14. Race - Ame Bleck, White					
21215-0020 d within 72 hours after plene. r than "waturat", or its fin Medical Examin completed by Fu	1 Never Merried 2 Married 3 Widowed XXDivorced	1 Yes YNo If Yes, Give Yeer or Detes:	1 ☐ Yes X			WHITE				
1 21215-0 ad within 72 ho ygiene. we than 'natur it, the Medical. Completed	15. Decedant's E		Occupation	t of working	16b. Kind of Bu	siness/Industry				
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The plant of the property of t	12 YEARS		SECRI	ETARY		CILLIA	CAL COLL ANI			
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Went with a store	CHARLES ALE	BIKER		MIN	INIE WOL	F				
Maryland 2 should be lise th and Mental Hy 7 is marked othe traumetic event	19e. Informent's Name/Ralationship	(Type, Print)	19b. Meiling Address (Street and Number	er or Rural Route Numi	ber, City or Town,	State, Zip Code)			
- 5365	BEVERLY JANE I	OVELACE (DAUG	H.) 822	LOYOLA	DRIVE, TO	WSON, MA	RYLAND, 2120			
B Ham Ham	20e. Method of Disposition	cemi	e of Disposition (Neme	of er plece)	Data	20c. Location -	City or Town, Stete			
Page of the Page o	XX Buriel 2 ☐ Cremetion 3 [4 ☐ Donation 5 ☐ Other (Special	JHemovel from State			RY 12-28	BALTIMO	RE, MD. 21229			
Desittmore, permit, Pages 1 a Department of He Important; if them any injury or other price.	21. Signeture of Funeral Service Lice			Address of Fecilit	XINS AND	SONS CO	MPANY			
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क विष् व	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):									
T 00 X	resulting in death) Last	d.								
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d by th	Pert II. Other significant conditions	STEEZ	ig in the underlying ceu	ise given in Perr			3 Probably 4 Unknow			
v requires v requires sign should be	Arkeriosa	Erosis.			24a. We per	s en eutopsy formed?	24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth?			
vital net included in the law certificate has rector, page 2 Be Comp						Yes 212 No	1 🗆 Yes 2 🗆 No			
C. Pa		T -					TLITES ZLINO			
yelclen: is certific director,	25. Was case referred to medical examiner?	Hospitel:		0.1	a of Deeth (Check only					
Physician: this certific ral director.	1 ☐ Yes 2 ☒ No 27. Mannar of Death	1 ☐ Inpatient 2 ☐ ER	•	4 (2) 14(ursing Home 5 Res	how injury occur				
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tal or Attending Priss after deeth. al Director: After t led in by the funers Certification:	4 ☐ Homicide datarmined	28a. Place of Injury - At home building, etc. (Specify)	i, tarm, straet, tactory,	οπισε	City or To	own, Stete)	er or noral noute reamber,			
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Hospital or Attending Ph. 18 4 hours after deeth. 18 Funeral Director: After this 19 filled in by the funeral edical Certification: 7	29e. Certifier Certifying P (Check only one)	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	end/or investigation, in	n my opinion, daa	th occurred et the time	, data and place,	end due to the ceuse(s)			
We was	29b. Signeture end tall a south a 29c. License number 29d. Date signed (Month, Dey, Year)									
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10				D 100						
Y.P	30. Neme end eddress of person who			D-3 - m '		27002				
011		M.D. 2300 Dula		Rd Ti	monium, Md	21093				
State Registrar	JAN 0 3 200	32 Registrer's Signature	D. Spor	KN						

DHMH 16 Rev 6/95

ZORN, BERTHA

NAME:



DR.CHITRA RAJAGOPAL M.D. 18111 PRINCE PHILIP DR.#327 OLNEY, MD 20832

32. Pegistrer's Signature

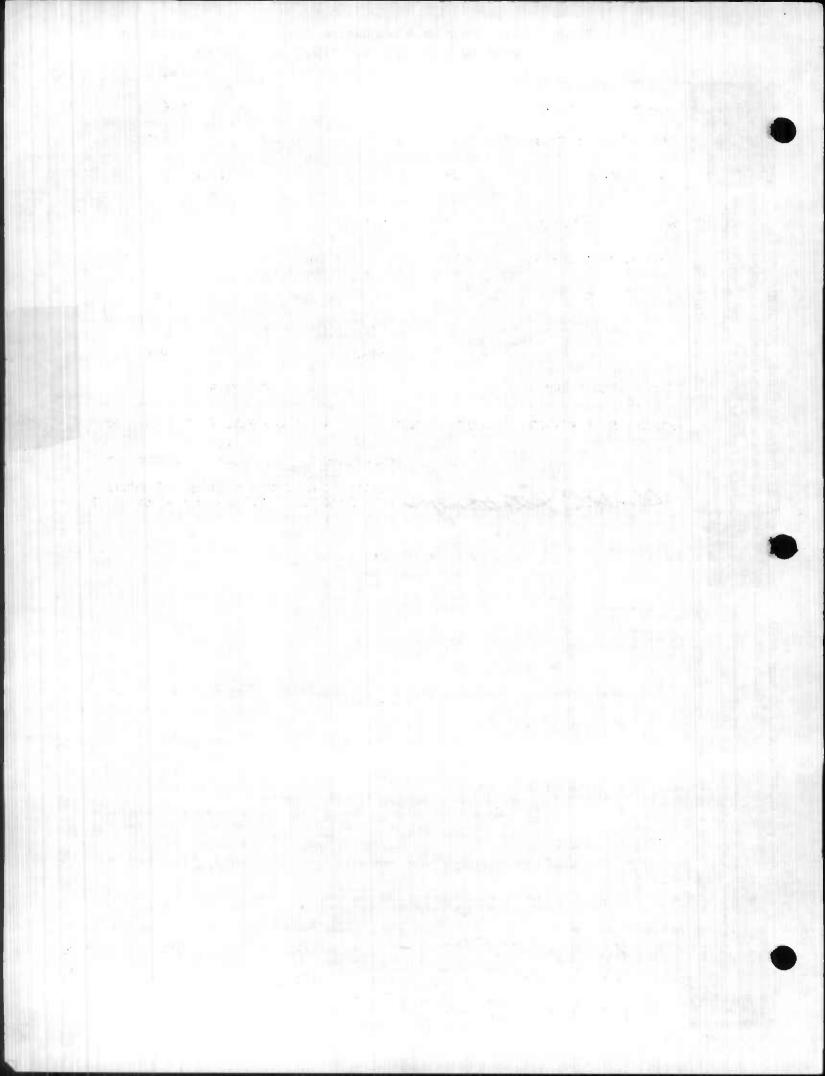
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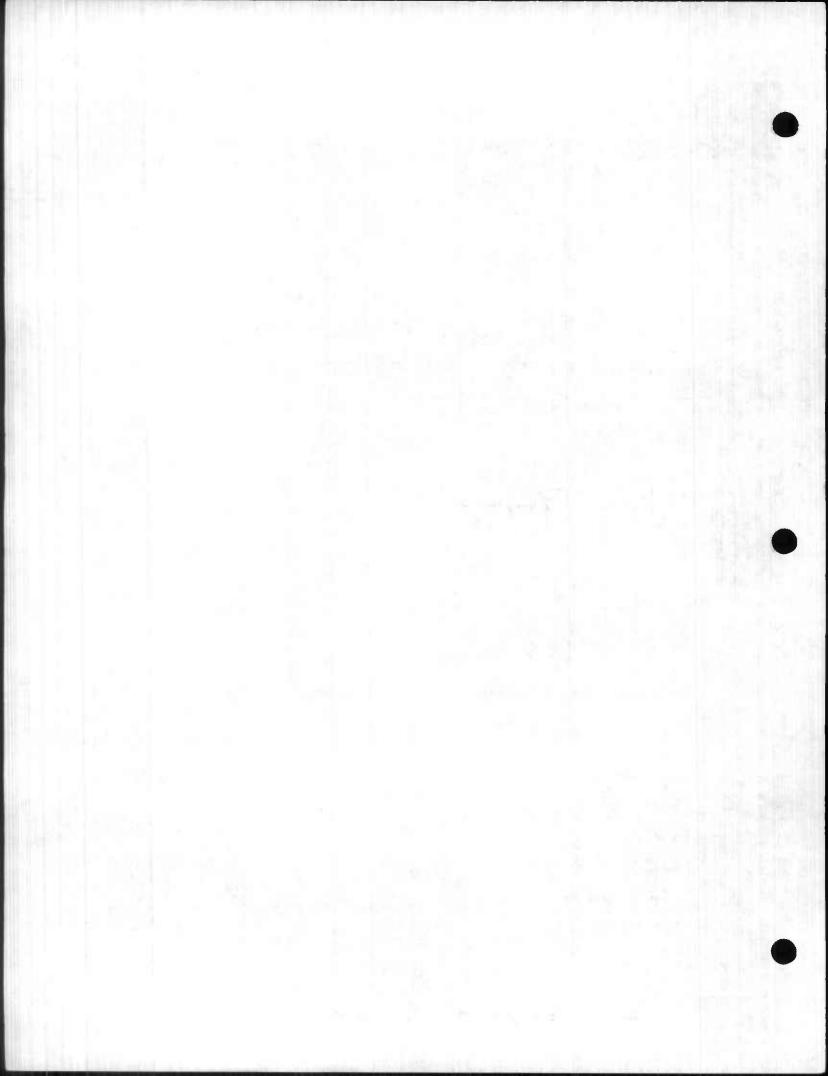


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State of Maryland / Department of Health and Mental Hygien

Certificate of Death

			(Jenincal	9 01	Deam		Reg. No.		
Physician	1. Decedant's Name (First, Middla, Caroline Wick		ine				2. Date of D Month Decemb	Day.	2 00 0	3. Time of Death 4:30 AM
/Medical	4a Facility Name (If not institution,	giva street and number)			4b. City, Town, or	Location of Dea		y of Death	
Examiner	Fox Chase Reha					Silver			gomer	·v
			ga (In yrs. last birth	day) If Under	1 Year				0	-
Funeral Director	327-30-7161	1□M 2KJF	00	Months rs.	Days	Hours Min		ay, Year) 1, 1908	Cali	place (State or For ntry) fornia
2	Usual Rasidance of Decedant 10a. Stete 10b. County	-	10c. City, Town	or Location						10d. tnside City Lir
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Te 528	10e. Street end Number			10f. Zip	Coda			10g. Citizan of	What Cou	ntry?
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me 2	11. Merital Status	12. Was Decedani	Evar in U.S.			Hispanic Origin? (San, Maxican, Puar	Specify Yas or N	o- 14. Ra		cen Indian,
E B	1 Never Merried 2 Marrie	if Yas, Giva		If Yas, spec			rto Hican, etc.)		ack, Whita, hv:Colo	
d d	3 □ Widowed 4 ☑ Divorced	Yaar or Datas:								
"natural", solds Em	15. Decedent's (Specify only highast		16a. C	Decedent's Usua 'Giva kind of wor	l Occup	pation during most of wo d)	orking	16b. Kind of E	Businass/In	ndustry
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Hygin C		ast)				18. Mothar's Na	ma (First, Middl	a, Maiden Suma	ma)	
marked off umatic even	Gustavus Woodso	n Wickliff	2			Minnie	Clyde N	(itchel		
d Men				Mailing Address	(Strace	and Number or R			State 7	n Code!
f Heelth and Mental Hygiene. them 27 le marked other than other traumatic event, tra M To Be Comp	19a. Informent's Name/Ralationsh Claire Antoine					d Street				
the de	20a. Mathod of Disposition		20b. Place of I	Disposition (Nan, crematory or o	na of	001	Data	20c. Location	- City or T	own, Stata
o H	1 Burial 2 XCramation 4 Donation 5 Other (Sp.						12/18/0	0 Po1+	ozzá 11	e, MD
rtan	21. Signature of Funaral Service L		Chesap	eake Cr		ass of Facility	12/10/0	n perr	SVIII	e, MD
Department of Heelth as Important: If item 27 is any injury or other training.	I andre	1		McGuir	e F	uneral S			on, I	o.c. 2001
_	23a. Part1. Entar tha disaasa, or o	complications that cause	d the death. Do no							Approximata
n and ial-trensit	rasulting in daeth)	b. Det	Duato (or as a co mentia							
ial-tren	Sequentially list conditions, if any, laading to immadieta cause. Entar Undarlying Causa (Diseesa or injury	Bearing T	Dua to (or as a co	onsequance of):						
value by siden and use as the bunal-trensit	Causa (Diseesa or injury that initiated avents rasulting in death) Last	c	Dua to (or as a co	onsequence of):						
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been s should							24a. Wa	s en autopsy formed?	a	Vara autopsy findir veilebla prior to omplation of cause f death?
page page	South services						15	Yas 2000	1	Dyas 2010
certificate has rector, page 2					-	26 Place of De	ath (Check only			
s certificate ha director, page To Be Com	axaminar?	Hospital:	ient all En/o	patient 3 DC	A Ot			sidance 6 0	thar (Saco	ihr)
fer this certific uneral director, on: To Be		28a. Data of trij		ma of 2	8c. Inju	ry et rk?	7	how injury occu		··y)
or: A	2 Accident investige	ation		М	1 [Yas 2□No				
rs after death. al Director: After t led in by the funera Certification:	3 Suicida 6 Could no determit	ned 288. Place of If	ijury - At homa, fam tc. (Specify)	m, straat, factory	, office		28f. Location City or T	(Street and Nun own, Stata)	nber or Rui	ral Routa Number,
within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. Addical Certification: To										
ompl ompl	29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signad (Month, Day, Year)									
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	30. Name and eddrass of person w				. 1	Day Card to	225	41220 0	D w d	MD 20
		HIKH	10801	LOC KWO	od .	or. Suite	e 323, S	Tiver S	hring	, MD 20
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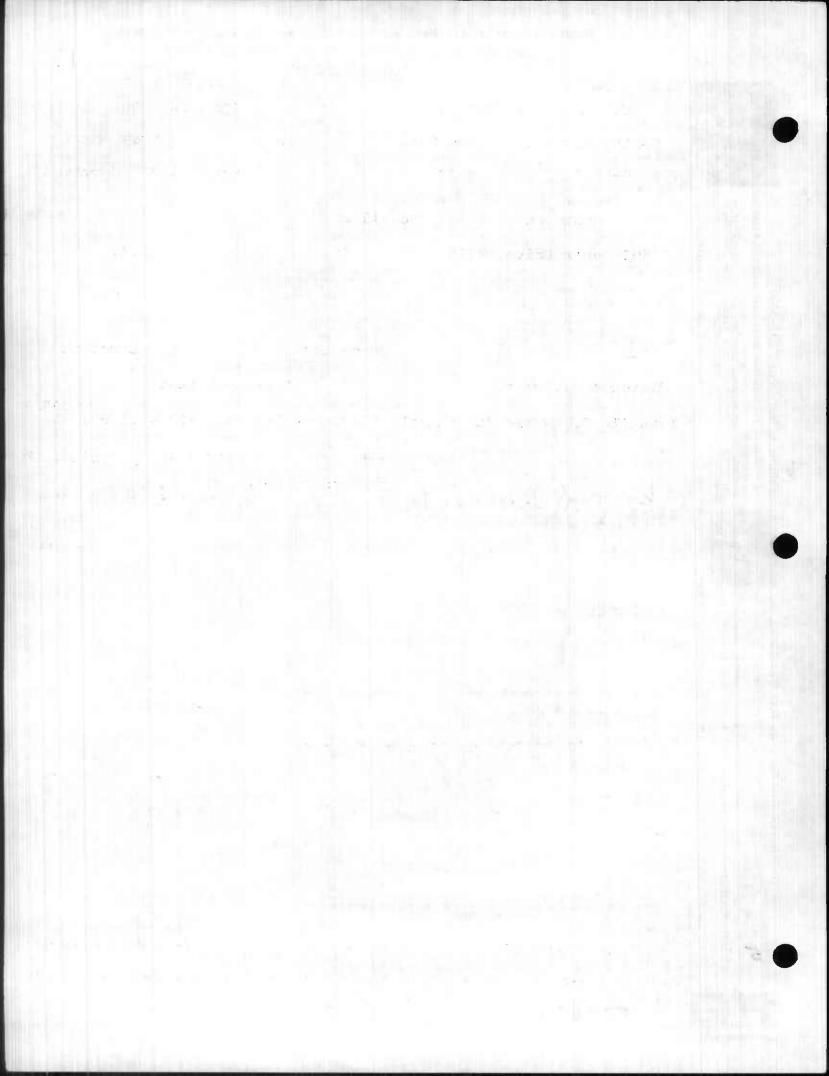


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State of Maryland / Department of Health and Mental Hygien

			Certificate of	Death	Re	eg. No.	46111			
100	1. Decedent's Name (First, Middle, La	st)		C. Maria	2. Dete of Deet Month		3. Time of Death			
Physician Medical	CLARENCE	L. AWKARD			DEC	16, 20				
Examiner	4a Facility Neme (If not institution, giv	e street end number)		4b. City, Town, or L	ocation of Deeth	4c. County o	f Deeth			
*	Montgomery (General Hospit		Olney			TGOMERY			
Funeral Director	5. Social Security Number 6. S 218-30-4828 Usual Residence of Decedent	ex 7. Age (In yrs. last	Yrs. If Under 1 Yea Months Deys		8. Date of Birth (Month, Dey, May 21	,1937	9. Birthplace (State or Foreign Country) Maryland			
land w	10a. State 10b. County	10c. City, T	own or Location				10d. inside City Limits			
Mary fish	MD Montgo	omerv I	Rockville				1 ☐ Yes X☐ No			
ith the Marylar or 28a-f show a rott ad a	10e. Street and Number	4	10f. Zip Coda		1	0g. Citizen of WI	net Country?			
3a o	14635 Bauer I	rive, #320	208	353		U.S.	Α.			
aryland 21213-0020 should be filed within 72 hours efter deeth with the Maryland and Mental Hygiene. Innerked other than "natural", or items 23a or 28e-f show umatic event, its Medical Exactine must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ② ☑ № 0 If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		- American Indian, , White, etc. Black			
n 72 hours n 72 hours nd cal Exe	15. Decedant's Ed	ducation 1	6a. Decedant's Usual Occi	upation		16b. Kind of Bus	inass/Industry			
be filed within 72 ho tal Hygiene. d other then 'nature event, the lead call Be Completed	(Specify only highest gre Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT usa retir	ed) ed)	king					
d with the month of the month o	12th	oonogo (1 45/ 01)	Carpent	ter		Const	ruction			
other vent	17. Fether's Neme (First, Middle, Last,				na (First, Middle, M)			
Ments Ments wrked sitce	Clarence E. A	wkard		Anne	tte Hut	ton				
paritimore, Marylang 4.14. permit. Pages 1 end 2 should be filled within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Mental page. To Be Compi	19a. Informant's Name/Relationship (Isabella F. Av						lete, Zip Code) 20832 lney, MD			
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filled within 72 hours at beperiment of Health and Mental Hygiene. mportant: if item 27 is marked other than "natural; or ny injury or other traumatic event, in Madical Examinate. To Be Completed by F	20a. Method of Disposition 1 → Buriel 2 □ Crametion 3 □ 4 □ Donation 5 □ Other (Specification)	Removal from State	e of Disposition (Neme of etary, cremetory or other pl Memorial (-			Spring, MD			
Baltimory permit. Pages 1 Depertment of F important: if the any injury or of page.	21. Signature of Funeral Service (Icer 23a. Part1. Entar tha diseese, or com shock, or heart failure. List only	Grendy S	R . 246 N.	ress of Facility N FUNERA Wash. S ying, such es cardiac	t., Roc	kville	Approximate			
Physician /Medical Examiner	Immediate Cause (Final diseese or condition rasulting in daath)		CANCER				Interval Between Onset and Death			
Section 2	rasuking in daam)	Dua to (or as	s e consequance of):				1			
OX 68/60, cartificate be executed nding physicien end use as the buriel-transit n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Disease or Injury that initieled avants resulting in death) Last	c	s e consequence of):							
daath ca daath ca attandii d for use	Part II. Other significant conditions of	ontributing to death but not resulting	og in the underfying cause of	iven in Part I	23b. Did to	bacco use con	tribute to the ceuse of death			
hat the death of ed by the attend deteched for us	Renal Insuff			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			3 Probably 4 Unknow			
(ecords, P.O. Bo) law raquiras that the death ca as been signed by the attend s 2 should be dateched for us, npleted by Physician/		surtius pulmo	NORY Dile	. 16	24a. Was a	in autopsy med?	24b. Wera autopsy findings evailable prior to			
The law requires the law requires the law seem signed, page 2 should be Completed by					1 🗆 Yı	es 2 🗷 No	completion of cause of daeth?			
VITAL HI lician: The li certificate he rector, pege	25. Was case referred to medical			26. Place of Dea	ith (Check only on	ne)				
hysician his cer al direc	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpatient 2 ☐ ER	VOutpatient 3□ DOA C	Whor:	ome 5 Raside		r (Specify)			
ding P. After t funer	27. Manner of Deeth 1 Natural 5 Pending investigation investigation	28a. Date of Injury (Month, Dey Year) 28	Bb. Time of 28c. Injury W		28d. Describe ho	ow injury occurre	d			
DIVISION Alternas after death or Alternas and Directors ed in by the Certifica	3 Sulcide 6 Could not b 4 HomIcide datamined	28e. Place of Injury - At home building, etc. (Specify)	a, farm, street, factory, office	9	28f. Location (Si City or Town	rreet end Numbe n, State)	r or Rural Route Number,			
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) 1 **Certifying Physicien: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as steted. 2 **Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner steted.									
withir To th comp	29b. Signature and title of certifier		29c. Lice	nse number	2	9d. Date signed	(Month, Dey, Year)			
50	by and by	-, mo	02	3630		Derrobe	18,2000			
9	30. Name and address of parson who FRANK J. MAYO.	completed cause of death (Hom 25	3a) (Type, Print) CEDERICK RA	#213	6 A TTHE	RSBURG	, mo 20877			
State Registrar	31. Date filed (Month, Dey, Yeer) DEC 2 0 20	32 Registrer's Signature	A. Spork			STATE OF				

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month CLIFFORD AWKARD 19, T. Dec 2000 3:55Pm 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Lorien Nursing Center Columbia | If Under 24 Hrs. | 8 Howard If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours | Min. 1 M 2□ F Months Yrs. 214-80-4762 32 Jan 29,1968 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5265 Riverdale Drive 21044 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XXYes 2□No If Yes, Give Vietnam Yeer or Detey. 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Medical 2 yrs Nursing Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence L. Awkard Alberta P. Thomas 19a. Informent's Name/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17802 Buehler Rd., #136, Olney, MD 20832 Isabella Awkard (Sister) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriet 2027Cremetion 3 ☐ Removel from State Metropolitan F/Serv 4 ☐ Donetjon 5 ☐ Other (Specify) 12/20/00 Alexandria, VA 22. Name end Address of Facility
Snowden Funeral Home, P.A. 21. Signature of Funeral Service License dell 246 N. Wash. St., Rockville, MD 20850 23e. Pert1. Enter the unsease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tritervet Between Onset and Death Immediate Ceuse (Finel disease or condition resulting In deeth) PNEUMONIA 4 WEUTC Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 N6 3 Probably 4 Unknown ITIV INFECTION 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? MAZNUTATION 1 Yes 2 No 1 ☐ Yes 2 ☐ Ho

Physician /Medical Examiner

Department of Important: If any injury or ange.

Physician

/Medical

Examiner

10a. Stete

Md

Funeral

Director

show

25a-f

ò Norms 23a

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Pages 1 and 2 should be in ment of Health and Mental H ant. If Item 27 is marked off jury or other traumatic aver

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Vital

of

Division

Attending Physician:

ò Hospital

To the Hosp within 24 ho To the Fune completely fi

notified at

Director

Funeral

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Completed

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Examiner Physician/Medical by Completed Be

sician end burial-transit physician s the burial USB this funeral After 24 hours efter death.

Funeral Director: A

Certification: To

edical

25. Wes case referred to medical exeminer?

1 ☐ Yes 2 DNo 27. Menner of Deeth 1 Netural 2 Accident 3 Suicide

29e. Certifier

(Check only one)

29b. Signature and title of certifier

5 Pending 4 Homicide

investigetion 6 Could not be

28a. Dete of Injury (Month, Day Year)

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other, Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Tyes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

, COLUMBIA IVID

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and plece, and due to the cause(s) end menner steted. 29c. License number 036974

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

29d. Date signed (Month, Day, Year)

DBZ 20, 2000 DAVID O. NYANTOM

21544

State Registrar

31. Dete filed (Month, Dey, Year) 2 1 2000 DEC

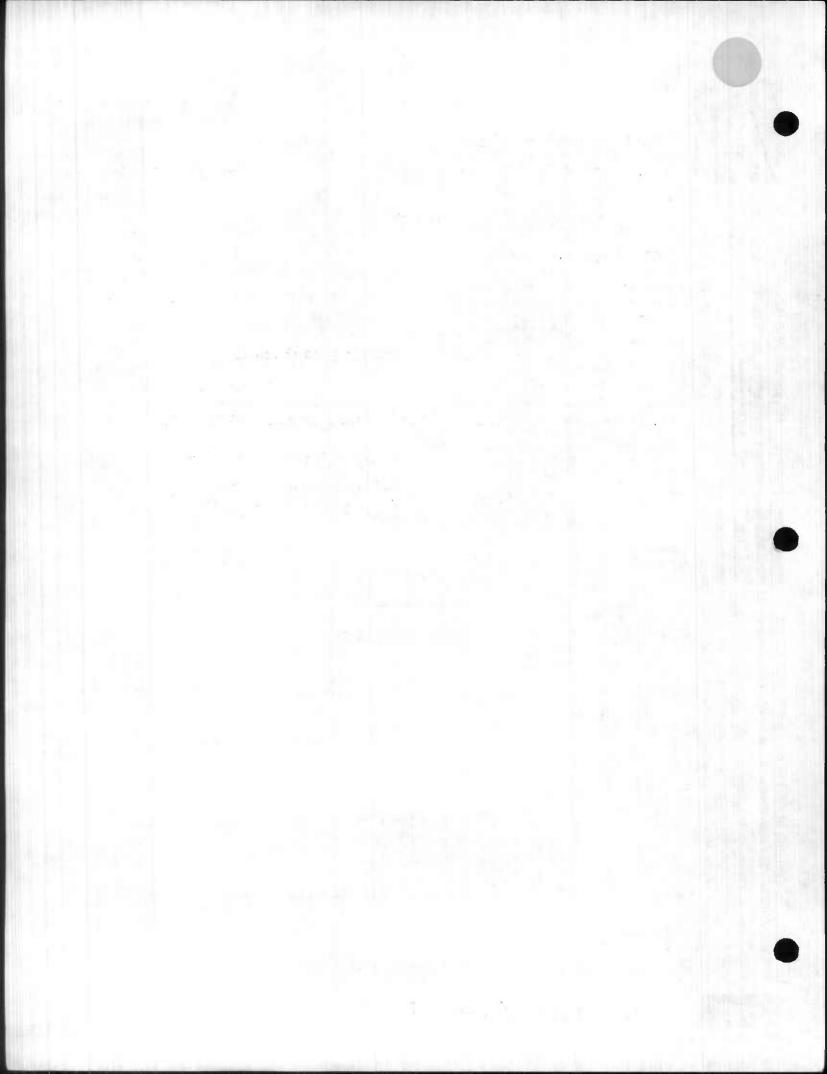
10724 LITTUS

32. Registrer's Signeture

PATJKENT

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 10724 LITTUB PATUKBAT PARKLWAY

ooks



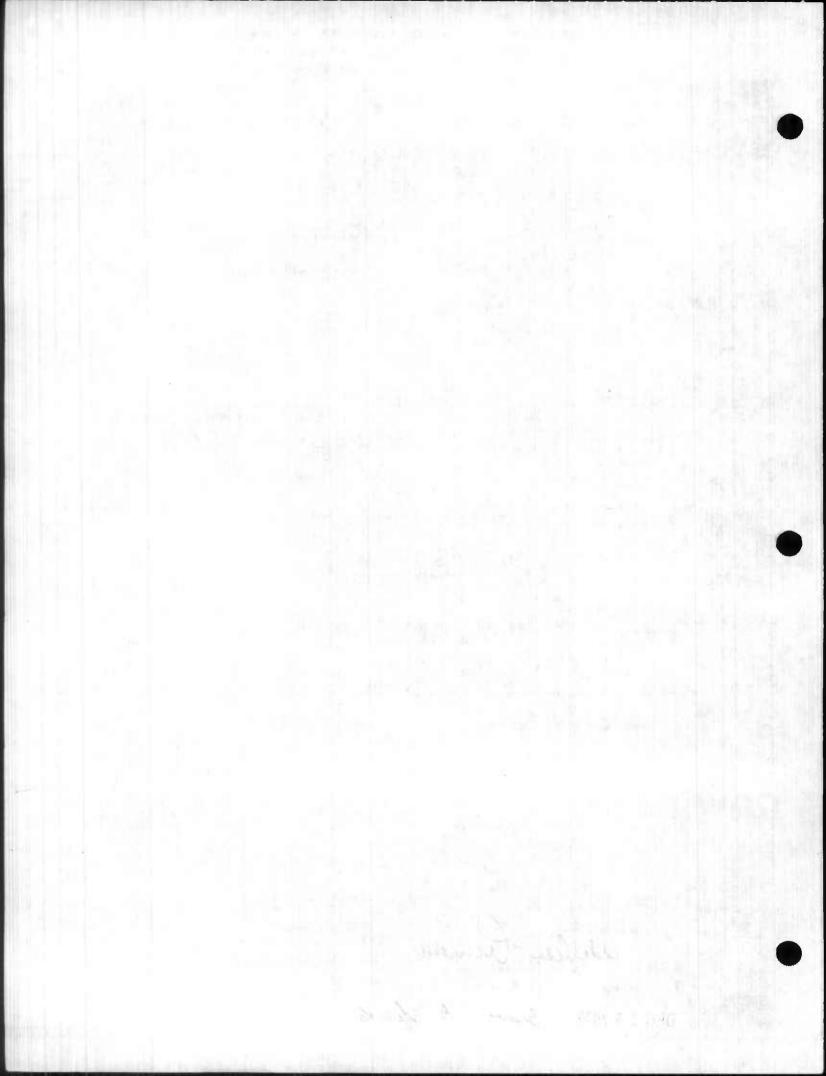
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Alkire 12, 2000 Dec mq00:80 Madaline /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner | Cumper Land Memorial Hospital Allegany 5. Social Security Number 7. Aga (In vrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** 10 M 20 F MD Yrs. 1909 Director 215-18-8652 91 Usual Rasidence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or Rems 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1□ Yas 2□ No Director Allegany Cumberland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? USA 21502 904 Lafavette Avenue death Funeral 12. Was Decadant Evar in U,S. Armed Forcas? 1 ☐ Yas ※☐ No If Yes, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hyglene. Important: If frem 27 is marked other than "natural", or frem any Injury or other treumatic event, the Medical Process Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Baitimore, Maryland 21215-0036 Specify Specibinite p ₩idowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 18b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Tire Company laborer 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Kelly (none) Nora Stump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 751 Maryland Avenue; Cumberland, MD21502 Delores J. Turner da Manda & Babosition 20b. Place of Disposition (Nama of cematery, cramatory or other place) Data 20c. Location - City or Town, Stata Donation 5 ☐ Other (Specify) 12/16 2000 Short Gap, WV Ahe Cemetery 21. Signature of Funeral Sarvice Licensee Scarpelli Funeral Home P.A. Cumberland, Maryland 23a. Part / Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting In death) Metabolic Failure l week Examiner Dua to (or as a consequanca of): Physician/Medical Examiner Malnutrition 2 weeks The lew requires that the death certificate be assecuted attending physician and for use as the burief-trensit Sequentially list conditions, if any, laading to immadiata cause. Entar Undarfying Causa (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequanca of): Severe Esophageal Dysmotility Box 68760. 6 months Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vitai Records, P.O. the detached signed by t 1 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed peen s completion of causa of death? certificate has page 2 1 Yas 2 No 1 Yas 2X No or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 10 After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Panding Invastigation To the Hospital or Attandin within 24 hours after deeth.
To the Funeral Director: Af completely filled in by the fu 1 Yas 2 No deeth. 8 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. edicai 29a. Certifier (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier Dec 13, D25406 2000 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) MAS Lamm M.D. 47 Virginia Avenue Cumberland MD 21502 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State 1 5 2000 Registrar DEC

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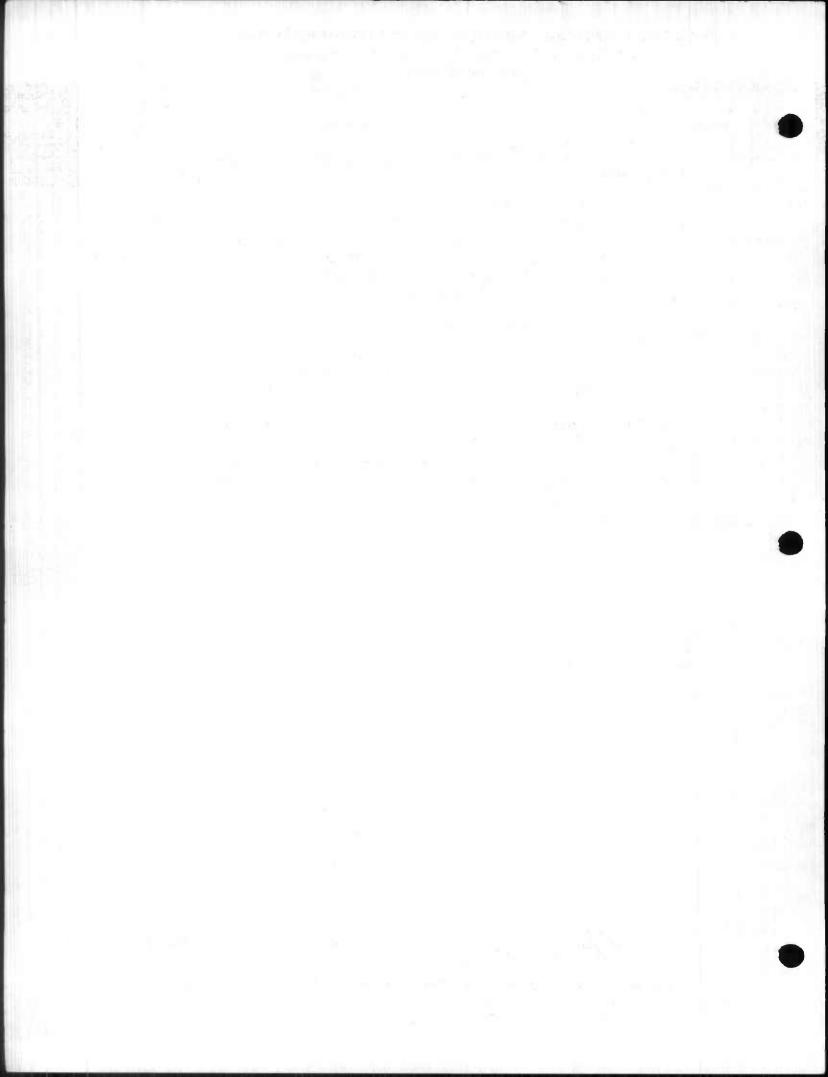


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State of Maryland / Department of Health and Mental Hygiene 00 42120

		(Certificate of	of Death	R	leg. No.	76160		
. Decedant's Nama (First, Middla, La	st)				2. Data of Dea Month	Day	3. Time of De		
Samue1	Baskin					er 15,2			
a. Facility Nama (If not institution, giv.	a street and number)			4b. City, Town,	or Location of Death	4c. County	of Death		
Rockville Nursin	9		H Hadaad W	Rockvi			gomery		
Social Sacurity Number 6. S 067-12-1430	ax 7. Ag 1⊠M 2□F	a (In yrs. last birth	Months Da		Hrs. 8. Data of Birth (Month, Day Nov. 9	, Year) , 1908	9. Birthplaca (Stata or F Country) New York		
Oa. Stata 10b. County		10c. City, Town	or Location				10d. Inside City		
aryland Montgome	orv.	Rock	ville				₽D Yas 2		
Oe. Street and Number	-1 y	ROCK	10f. Zip Coo	la	1	0g. Citizan of V	What Country?		
516 Longhorn Cres	scent		208	50		United			
1. Marital Status	12. Was Decedant	Evar in U,S.			? (Specify Yas or No- uarto Ricen, atc.)		e - Amarlcen Indian,		
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15. Decedant's Ed	ducation	16a. C	ecedent's Usual Oc	cupation		16b. Kind of Bu	usinass/Industry		
(Specify only highest gra	da complated) Collaga (1-4or 5	()	Giva kind of work do ifa. DO NOT usa re	na during most of tired)	working				
11	Oblaga (1-40) C	,+,	Salesman			Wholesa	ale Plumbing		
7. Fathar's Nama (First, Middla, Last)					Nama (First, Middla,				
Harry Baskind				Rose	Sander				
9a. Informant's Name/Ralationship (Typa, Print)	19b. /	Malling Address (Str	eat and Number o	r Rural Routa Numbe	r, City or Town,	Stata, Zip Coda)		
Harold Baskin/Son	1	51	6 Longhor	n Cresce	nt Rockvil	le. MD.	20850		
Oa. Mathod of Disposition		20b. Place of D	Disposition (Nema o	f	Data		City or Town, Stata		
P⊠Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Commatary, cramatory or othar place) Dec. 18, Dec. 18 Dec. 18 Dec. 18 Dec.									
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► //	5				Danzansky Pike. Rock		rg Memorial MD. 20852		
23a. Part 1. Entar the disease, or com shock, or heart failure. List only	plications that caused	tha death. Do no					Approximate Interval Between		
Shook, of haart failura. List only	ona causa on aaon iii	ia.					Onsat and Dea		
mmediata Causa (Final	Conge	ctive He	art Failu	ro			years		
asulting in death)	a	Dua to (or as a co		1.0			, , , ,		
				e			years		
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sequantially list conditions, any, leading to immediata ausa. Entar Undarlying ausa (Disaasa or Injury nat Initiated avants									
ausa (Disaasa or Injury	c. Anemi	a Dua to (or as a co	nonculance off:				years		
asulting in death) Last									
	d. Chron	ic Myelo	genous Le	ukemia			months		
art II. Other algnificant conditions of	ontributing to death b	ut not rasulting in t	ha underlying cause	givan In Part I.	23b. Did to	obecco use co	ntribute to the ceuse of o		
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							of death?		
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5. Was casa rafarrad to medical axaminar?				26. Placa of	Death (Check only or	na)			
1 Yas 2 No	Hospital: 1 ☐ Inpatia	nt 2 ER/Outp	atlent 3 DOA	Othar: 4KI Nursir	ng Homa 5 🗆 Rasid	anca 6 Oth	ar (Specify)		
7. Manner of Death	28a. Data of Inju (Month, Day	y Yaar) 28b. Tir	na of 28c.	njury at Work?	28d. Dascribe h	ow injury occur	red		
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3 ☐ Suicida 6 ☐ Could not be datermined	28a. Place of Inji	ury - At homa, fam	n, straat, factory, off	се			per or Rural Routa Numbe		
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9b. Signatura and titla of certifier			29c. Lic	ansa number	2	29d. Data signe	d (Month, Dey, Year)		
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			ston Driv	e, Rockv	ille, Mary	Land 20	1852		
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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Villiam tar Dec 10:25 an 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sex 17. Georges Clunton Prince Hospital 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dev. Year) Birthplace (State or Foreign Country) 79 28,1921 Virginia Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d, Inside City Limits Prince Georges 1 TYes 2 No Clinton 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 9211 Stuart 20735 United States ane 12. Was Decedent Ever In U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) UNKNOWN Grounds Keeper 18, Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maude William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) L'Enfant Square S.E. Washington D.C. 20020 laduanter 2402 Ballor Valoria 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 12.15.00 Laurel, MD 4 Donation 5 □Other (Specify) Anatomic Gift Fnd. 22. Name and Address of Facility Anatomic Gift Foundation 21. Signature of Funeral Service Licensee 120 Bultimore Ave. Laurel, Hd 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fibrilation Due to (or as a consequence of): End stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Peripheral Vas Col bue to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 P Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Hospital or Attanding Physician:

death.

To the Hosp within 24 hor To the Funa completely fi

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Physician

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Funeral

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Baltimore, Maryland 21215-0036

physician and the burial-transit 88 for use as signed by the d should I ils certificate has il director, page 2 : Sid

Physician/Medicai þ Completed Be 2

Examiner Certification: in 24 hour.
The Funeral Dirac.
Tilled in by

25. Wes case referred to medical 1□Yes 2⊡No

27. Manner of Death 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

1 Inpatient Dete of Injury (Month, Dey Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify)

28c. tnjury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Rointan Farabl

29a. Certifier

(Check only one)

D43446

29c. License number

29d. Date signed (Month, Day, Year) 12.15.00

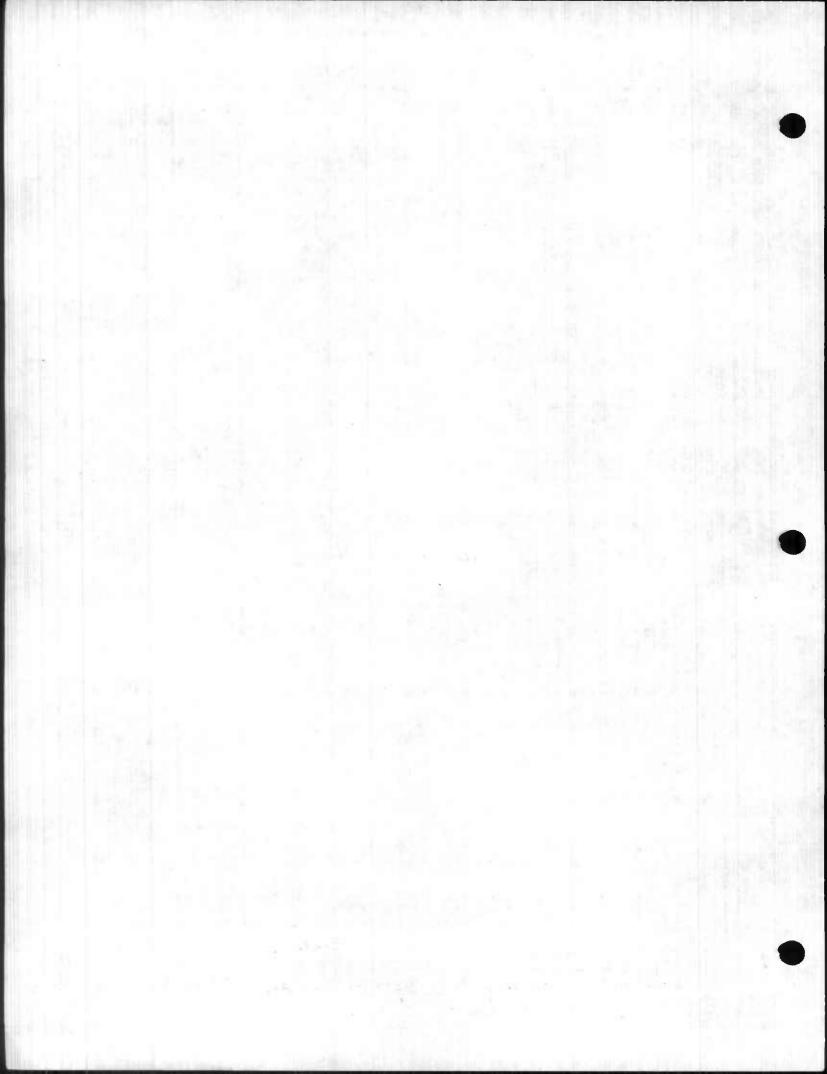
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 Georgia Av. suit 3-35 SILVER SPEING MD

State Registrar

31. Date filed (Month, Day, Year)
DEC 1 8

FARAHIFAR M.D 32. Degistrar's Signature



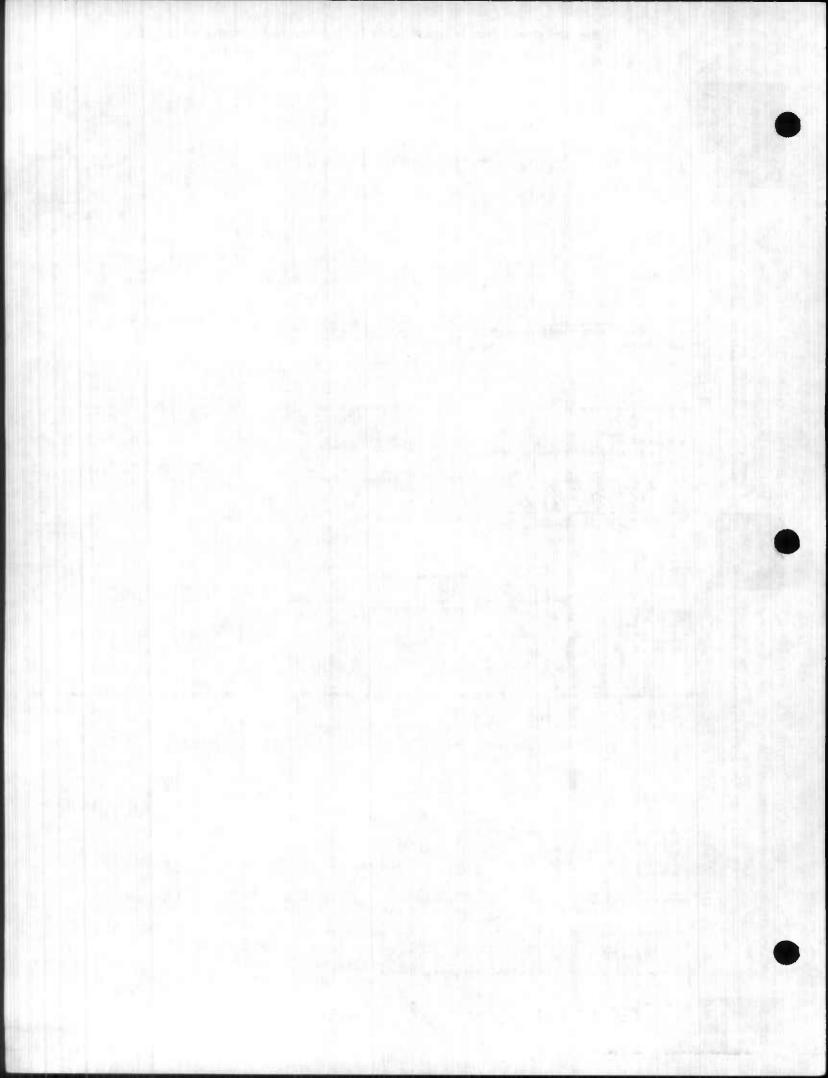
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State of Maryland / Department of Health and Mental Hygiene

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Physician	1. Decedent's Nama (First, Middle, Last)		2. Date of Death Month	Day Ye	ar						
/Medical	SARI BLACHARSKI 4a Facility Name (If not institution, give street end number)	4h City Town or	DECEMBER								
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uneral irector	5. Social Security Number 148-09-9732 6. Sax 1 M F	1 Yaar If Undar 24 Hrs Days Hours Min		9. 18 NE	Birthplace (State or For Country) W JERSEY						
ahow sd.at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Lir						
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0 4 0	106. Street and Number 107. Zip 919 GRANDIN AVENUE 20	Code 0851			Country?						
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Important: any injury once.	21. Signature of Funeral Service Licenses DANZANS	d Address of Eacility KY-GOLDBERG	MEMORIAL	CHAPELS	INC.						
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To the compla	29b. Signature and title of certifier Tomoko, MD 29c	DS1916 Pike, Ph	? Z ²⁹	d. Date signed (M	onth, Day, Year) M 14, 201						
	30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)	N. La DI	MB 0110	partil	1/2 mn no						
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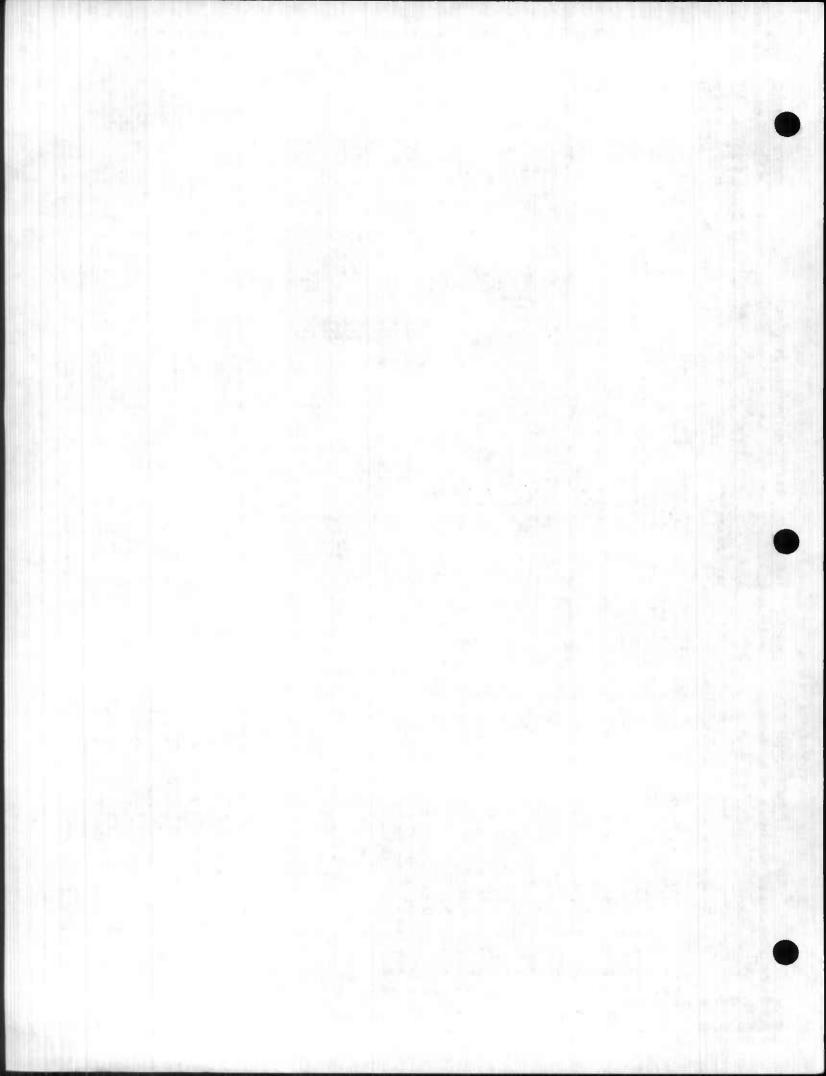
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State of Maryland / Department of Health and Mental Hygiene 0 42123

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Examiner	4a Facility Nama (If not institution	n, giva street and nur	m <i>ber)</i>			4	b. City, To	wn, or Lo	cation of Deat	7	ty of Death		
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Funeral	5. Social Security Number	6. Sex	7. Aga (In yrs. lasi	birthday)	If Unda Months	r 1 Yaar	If Undar Hours		8. Data of Bir	th Veer!		olaca (Stata o	r Foreign
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with the Marylan s or 28s-t show be notified at Director	10e. Street and Number				10f. Zi	p Coda				10g. Citizan of	What Cou	ntry?	
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T of To	20a. Mathod of Disposition	3 □Ramoval from	State cem	e of Dispo atary, cran	natory or	othar plec		1	Data	20c. Location			
Page 19 Page 1	1 Burial 2X Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Chesapeake Cramatory, Inc. 12/16/00 Beltsv								sville	e, MD			
THE STATE OF	21. Signature of Funeral Service	Licenseg					s of Facili		1	-			-
FOLES	1	11/200	M0098	6	CAFA	Ster	ohen	D. L	ohrmanr	1, P.A.	MT	2120	
	23a Parti. Epter tha disaasa, o	r complications that o	ausad the daeth	Do not ent						Tows	on, MI	Approximet	
hydiaian	anock or haart failura. Lis	only one cause on e	ach lina.									Intervel Bet Onsat and	ween
Physician /Medical	Immediata Cause (Final		01	11.		00	000				- !	1/	h_
Examiner	disease or condition resulting in deeth)	a	B/0	adde	7	Un	100				1	16 m	wy 5
E IN			Dua to (or as	s a conseq	uenca of):					1		
i ii c		b											
ing physician and is as the burial-transit	Sequentially list conditions,	1200	Dua to (or es	s a conseq	uenca of	:							
ourie I	Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or injury												
hysic that	that initiated evants rasulting in death) Last		Dua to (or as	a conseq	uance of)	:							1
ertificate be axecuted ling physician and se stha burial-transit													
		d									1		
: The law requires that the death of the case has been signed by the attend page 2 should be detached for us Completed by Physician	Part II. Other significant conditi	ons contributing to de	eath but not resultir	ng In tha u	ndarlying	causa giv	an in Part	1.	23b. Dld	tobacco use o	ontributa t	o the cause	of death?
t the tach the tach									1 0	Yes 25 No	3 Pro	bably 4	Unknow
gned be da													
is in D										an autopsy	24b. W	era autopsy	findings
been s should									реп	ormed?	CC	vailabla prior of of daath?	causa
has pa 2													
cate ha									10	Yas 2 No	1	☐ Yes 2☐	No
s certificate director, pag	25. Was casa rafarrad to medica axaminar?					044		a of Deat	h (Check only	one)			
A Sign	1 Yas 250 No	-		/Outpatier			4 🗆 141	ursing Ho		idance 6 🗆 O		(y)	
After ti funere funere tion:	27. Mannar of Death . 1 Pandi	28a. Date	of Injury th, Day Year)	b. Tima of Injury		28c. Injur Wor			28d. Describe	how injury occ	urred		
he Hospital or Attending Ping Lay Abour stardaath. The Funeral Director: After the pletaly filled in by the funere edical Certification:	2 ☐ Accident invast	igation			М	10	Yas 2□	No					
or de by ti	3 Suicida 6 Could deterr	ninad 20d. Fleue	of Injury - At home	a, farm, str	aat, facto	ry, office		7	28f. Location	(Street and Nur wn, Stata)	n <i>ber</i> or Rur	el Route Nun	nber,
To the Hospital or within 24 hours after To the Funeral Dir completaly filled in Medical Cert		Odinar	ing, a.e. (Dipoeny)							,			
A fille	29a. Cartifiar 12 Certifyl	ng Physician: To tha	best of my knowle	dge, death	occurred	at tha tin	na, data ar	nd placa,	and dua to the	cause(s) end r	nenner as :	steted.	
within 24 hours after dash. To the Funeral Director: A completaly filled in by tha f	(Check only 2 Medical one)	Examiner: On the ba	asis of axamination nar statad.	and/or in	vastigatio	n, in my o	pinion, dee	oth occur	red et the time,	dete and place	a, and due t	tha cause(5)
Me of the	29b. Signatura and itla of certific	170			29	c. Licans	a number			29d. Data sign	ned (Month)	Day, Year)	
51-0	Pull	Blans 1				021	92	9		121	10/2	000	
(p	lat (Lecture 11				2)	, .			14	13/2	,000	-
	30 Nama and addrass of person		a of daath (Item 23	Ba) (Type,	Print)	- 0.		0.44	1000	11211	,		
	PAUL CRAND,				NC CO	, 51	40111	VIL	טוון	21209			
State	31. Data filad (Month, Day, Year	32.9	egistrar's Signatur		1	2.11							
Dominton		71801 /	K-AAAAAA	17	MA	CEA ALA	T.						



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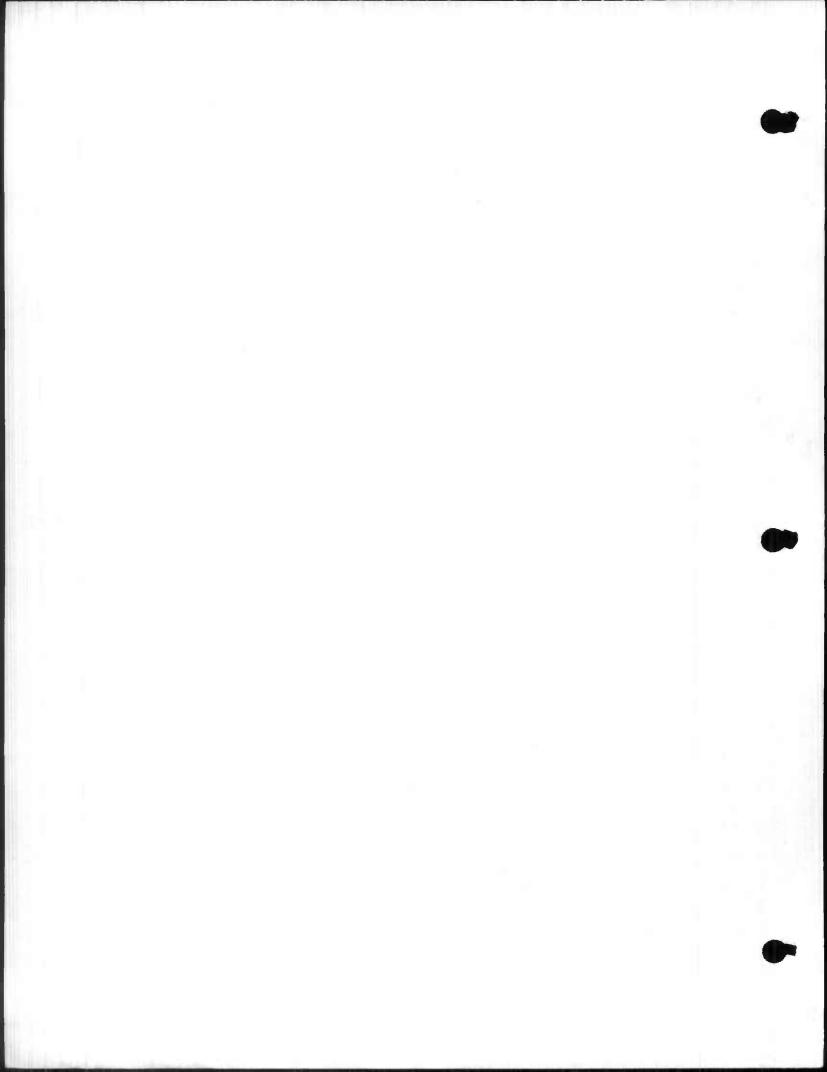
State of Maryland / Department of Health and Mental Hygiene

			Certificat	e of Death		Reg. No.	42124
	1. Decedent's Neme (First, Middle, Last,)			2. Deta of De		3. Time of Deeth
Physician	GEORGE	H. BRA	DFORD SR.		DEC.	16.	Yaar 2000 12:10 A
/Medical	4e Facility Nama (If not institution, giva		DI OLD DITE	4b. City, Town, or L			
Examiner						1 211 237	
	SUBURBAN HOSP			BETHESD			NTGOMERY
eral	5. Social Security Number 6. Sec.	X 7. Age (In yrs. I	Months	1 Year If Under 24 Hrs. Deys Hours Min.	8. Date of Bir (Month, De	th y, Year)	Birthplece (Stelle or Foreign Country)
tor	145-14-2806	75	Yrs.		AUG. 2	0,1925	NEW JERSEY
	Usuel Residence of Decedent						
rector	10a. State 10b. County	10c, City	y, Town or Location				10d. Inside City Limits
to	MD. MONTGOM	ERY	KENS	INGTON			1X Yes 2 □ No
Director	10e. Street and Number		10f. Zig	Code		10g. Citizen of V	What Country?
	libra gramme.	A 17 Mary		00000	12.07		
Fa		AVE.	0 40 14 - 0	20895		U,	S - A - e - American Indian,
Funeral		12. Wes Decedent Evar in U, Armed Forces?	If Yes, spe	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto	Rican, etc.)		ck, Whita, atc.
	1 Nevar Merried 2 Merried	1 X Yes 2 No 194	3- 1□ Yas	212 No Specify:		Specify	<i>r</i> :
by	3 Widowed 4 Divorced	Yeer or Detes: 19		A		- Cpoonly	WHITE
è	15. Decedent's Edu		16e. Decedent's Usu	el Occupetion rk done during most of work	kina	16b. Kind of B	usiness/Industry
Completed	(Specify only highest grade Etementery/Secondary (0-12)	Cotlege (1-4or 5+)	life. DO NOT u	se retired)	9		
FO		4	PURCHAS	ING ADMINISTR	ATOR	DISC	LOSURE INC.
	17. Father's Neme (First, Middle, Last)			18. Mother's Nem			
o Be C	HARRY A.	BRADFORD			ELIZABE	יחש שה	ROLD
F			10h Mailine Adding	(Street and Number or Ru			
	19a, Informent's Neme/Reletionship (Ty				er noute Numb	er, Only or rown,	Store, Lip Code)
		FORD/WIFE	SAME AS	- 4			
	20e. Method of Disposition 1 ☐ Burial 2 🎇 Cremetion 3 ☐ F		lece of Disposition (Na emetery, cremetory or o		Dete	20c. Location -	City or Town, Stete
	4 Donetion 5 Other (Specify)		HAMBERS CI	REMATORY 1	2/18/00	RIVER	DALE, MD.
4	21. Signature of Funeral Service Liganse			d Addrass of Facility			
Sign	>1/1/1/10/	10.00					ELAND AVE.
	W. W. Guan			RS FUNERAL HO			ERDALE, MD.207
10	23a. Pert1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused tha daath ne ceuse on eech line.	n. Do not anter tha mod	la of dying, such es cardiac	or respiretory a	rrest,	Approximata Intervel Between
n							Onset and Death
al	Immediate Cause (Final disease or condition	PNEUMONI	۸				10 DAYS
er	resulting in deeth)		r es a consequence of)				
وَ ا				TODATE			LONG
Ē		0	ASCULAR ACC	TDEMIS			STANDI
Examiner	Sequentially list conditions, if eny, leading to immediate	Due 10 (0)	r as e consequence of):				
	if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	D					
edical Examir	resulting in death) Last	Dua to (or	as a consequence of):				
. ≥		d,					
a L							
Sic	Pert II. Other significant conditions cor	ntributing to death but not resu	ulting in the underlying	ause given in Pert I.	23b. Dld	tobacco use co	ntribute to the cause of death
Physician/	CODOSTATOR ADDRESS	DV DIGEAGE			10	Yes 2 No	3 □ Probably 4 🎇 Unknow
by	CORONARY ARTE	KI DISEASE					
8						an eutopsy	24b. Were eutopsy findings available prior to
Completed					pend	ormed?	completion of cause of deeth?
E							
ပ္ပ			OR THE REAL PROPERTY.		10	Yas 2 No	1 ☐ Yes 2 ☐ No
Be	25. Wes case referred to medical examiner?			26. Piece of Dea	th (Check only	one)	
2	1 ☐ Yes 2 🕅 No	lospitel: 1 🖾 tnpatient 2 🗆	ER/Outpetient 3 De	OA Other: 4 Nursing H	ome 5 Resi	idence 6 Oth	er (Specify)
	27. Menner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of	28c. Injury et Work?	28d. Describe	how injury occur	red
읖	1 Neturet 5 Pending 2 Accident investigation	(Month, Day real)	Injury M	1 Yes 2 No			
f Ca	3 ☐ Suicide 6 ☐ Could not be	28e. Plece of tniury - At ho	me, ferm, street, fector	v. office	28f. Location (Street end Numb	per or Rural Route Number,
Certification:	4 Homicide determined	28e. Plece of Injury - At ho building, etc. (Specify	1)		City or To	wn, Stete)	
	COn Contillor 4TO 0 4M 1 - Dt	Interest Was the state of the Land					
edicai	(Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinet	wiedge, deeth occurred tion and/or investigation	et the time, dete and piece , in my opinion, deeth occur	, end due to the rred at the time,	date end plece,	enner es stated. and due to the ceuse(s)
	one)	end menner steted.				49.3.33	
2	29b. Signature and title of certifier	11- 0	29	c. License number		29d. Dete signe	d (Month, Dey, Year)
	mymil lu	M SW		D21435		DEC	18, 2000
	30. Neme and addrass of person who co	minuted cause of death (from	23a) (Tune Print)	DELTASI		DEC.	20, 2000
		V		CAT DADY DD	CITIUM	D CDDTM	MD 00000
	IRA PAUL KREF 31. Date filed (Month, Day, Year)	32 Registrer's Signer		CAL PARK DR.	طلاسلان و	V PLUTIA	יייייייייייייייייייייייייייייייייייייי
State	DEC 1 9 200	and the second s	4 Ann	Mar			
-1013-016-216	1127. [34 /111	ALC: NO. of Concession, Name of Concession, Na	mi. dicit	Land La			

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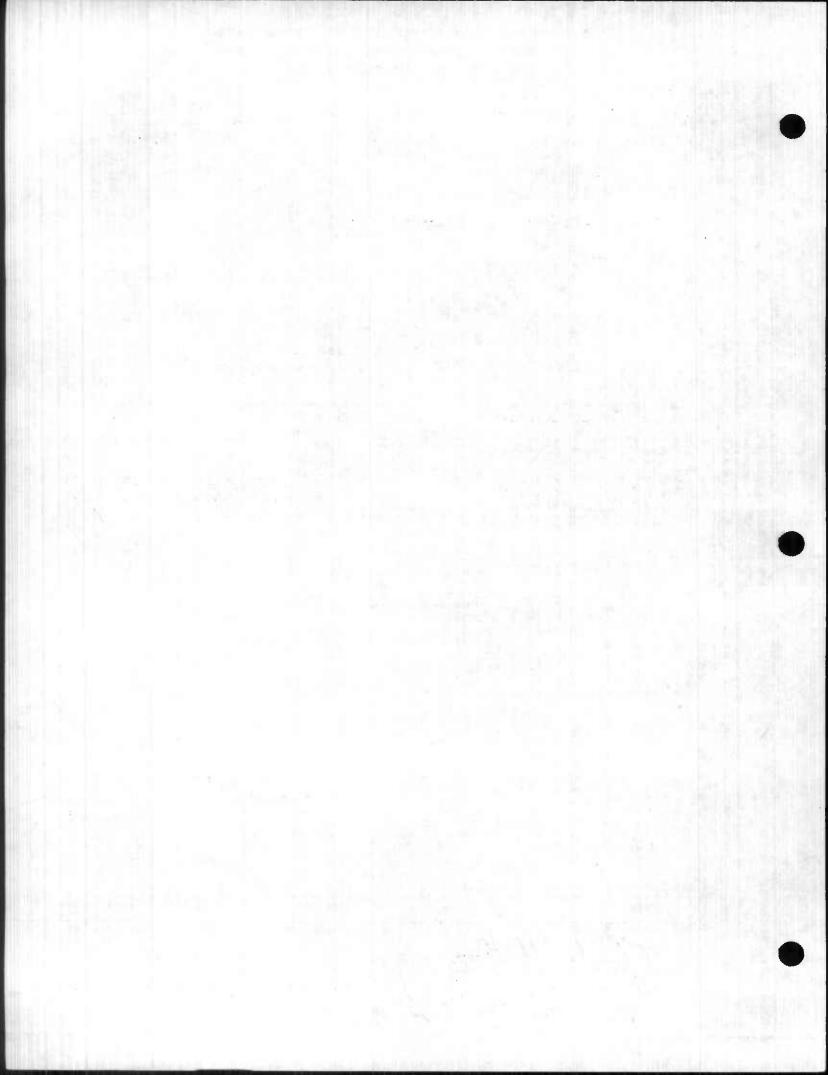
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	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	ENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	E	7			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH			
	Shirley Brow	une			MONTH DAY		2:20 P M			
				NOER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign			
	218-21-3805 1 9a. FACILITY NAME (If not institution, give street	M 2 AF	57 YRS. MON	CITY, TOWN OR LOCATION OF E	March 17,1	1943 Tri	nidad			
DIRECTOR	Montgomery General	Hospital		lney	ney Montgomer					
REC	10e. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCATION		10d, INSIDE CITY				
	Maryland Montgom	nery	Silver	Spring			1 TES 2 NO			
FUNERAL	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
NE P	3022 Hewitt Avenue			20906		USA				
E	11. MARITAL STATUS 12 1 Never Married 2 Married	P. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic	NIC ORIGIN? (Specify Year	or No- 14. RAC	E - American Indian, ck, White, etc.			
B≺	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES	1 TYES 2 NO Spec			Black			
	15, DECEDENT'S EDUCATI	ION	16a. DECEDENT'S USUA	L OCCUPATION	16b. KIND OF BUSI	NESS/INDUSTRY				
Ē	(Specify only highest grade con Elementary/Secondary (0-12)	college (1-4 or 5+)	(Give kind of work of life. Do NOT use retir	one during most of working ed.)						
AP.	12		Home Healt	ch Aide	Health (Care				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N	AME (First, Middle, Maiden S	urname)				
BE	Andrew Quash			Agatha						
P	19a. INFORMANT'S NAME (Type/Print)			RESS (Street and Number or Rural			17102			
- 1	Deryck Henry / Son		931 Nor	th Front Stree	et Apt 501,	Harrisb	urg, PA			
	20a. METHOD OF DISPOSITION 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal	from State 20b.	PLACE AND DATE OF DIS stery, crematory or other pl	Position (Name of Crematory	12/21	ATION — City or To				
	4 Donation 5 Other (Specify)		etropolita	22. NAME AND ADDRESS OF F		xandria,	VA			
				Francis J. Co.		al Home,	Inc.			
	Michen S	tole		00 University	y Blvd., W,	Silver	Spring, MD			
	23. PART I. Enter the diseases, or com shock, or heart fellure. List	phications that caused only one cause on as	tha daath. Do not a ich Ilna.	ntar tha moda of dying, au	ch aa cardiac or reapire	story arrest,	Approximate Interval Between			
	IMMEDIATE CAUSE (Final disease or condition									
1	disease or condition resulting in death) a. Denote to (OR AS A CONSEQUENCE OF):									
_		CILL I	Cu thile	1 4			2.4			
ō l	Sequentially list conditions, If any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	mecan			aweins			
CAT	cause. Entar UNDERLYING	distritu	ronal des	ont			14000			
E	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF):				pul			
CERTIFICATION	resulting in death) LAST	dialet	is mellitu	1			years			
AL C	PART II. Other algnificant conditions co	ontributing to death bu	it not resulting in the	undariving cause given in	Part I. 24s. WAS AN A	ITOBSV 246	. WERE AUTOPSY FINDINGS			
<u>র</u>					PERFORM	IED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
					1 TYES 2	THO THE	DF DEATH?			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES	NO UNCERTAL	NIP		1 WES 2 NO			
M	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH (Ch							
is		OSBITAL: Inpatient 2 - ER/Outpu		1ER: Nursing Home 5 □ Residence	8 Other (Specify)					
H	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. DESCRIBE HOW IN.	JURY OCCURED				
BY	1 Natural 5 Pending 2 Accident investigation			1 YES 2 NO						
COMPLETED	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY building, etc. (Speci	— At home, farm, street,	factory, office	281, LOCATION (Street and City or Town, State)	d Number or Rural I	Route Number,			
2	29a. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the best of my knowle	idge, death occurred at 5	he time, data and place, and dur	lo the council and a					
ğ	one) 2 MEDICAL EXAMINER: O	n the basis of examination	and/or investigation, in	ny opinion, death occured at the	time, date and place, and	or as stated.	t) and manner as stated			
	296. SIGNATURE AND TITLE OF CENTIFIED			29c. LICENSE NU						
BE	Unula X P.	14)		Zac. ElGENSE NO	Vale	29d. OATE SIGNED				
임	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETEO CAUSE OF OEA	TH (ITEM 27) (Type, Print)	390	FERRARA P	P. MIHO	ATON			
	Mark Ros	en ND	Silver	· Spring. 1		MARYL	AND 20906			
DEC 1 9 2000 Server B. South										



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		1/4/01 y					Octuno	ale of	Death	10.0-1-10	Reg. No.			0.7:	N M
sician	Decedent's Nama (First, Middla, Last)								Month						
edical	Leon Bryant, Jr. 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or L									December 11, 2000 20:05 Location of Death 4c. County of Death					5
miner										R SPRING MONTGOMERY					
ral	5. Social Security		6. Sax		7. Aga (In	yrs. last birti		dar 1 Yaar	If Under 24 Hr				9. Birthola	ca (Stata or	Foraign
tor	454 83	9725	17	M 2□F	28	,	rs. Month	hs Days	Hours Mir	June 1	bay, Year)	72	VA Country	V)	
Department of Heelth and Mental Hygiene. Important; if Item 27 is marked other than "natural", or fisms 23s or 28s-f show any Injury or other traumatic event, the Medical Exercises must be notified at pace. To Be Completed by Funeral Director	Usual Rasidance			10a City Tarre			as I posting							10d. Insida City Limits	
	10a. State 10b. County 10c. City, Town or Location												100	1 Yas	
	MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda									10g. Citizen of What Country?				X	
ā	1715 Mayboy Ct										USA				
Funerai	11. Manital Status 12. Was Decedant								Hispanic Origin? (
	1 ☑ Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☐ I ☐ Yas 2 ☐ I ☐ Yas 2 ☐ I ☐ Yas Giva Yaar or Datas				2 1 No				an, Maxicen, Pus	rto Hican, atc.)		Black, Whita, etc.			
by					Datas:	1 ☐ Yas			Specity:		S	Specify: Black			
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duic	Elementery/Sec	condery (0-12))	College (1-4or 5+)	1	mputer			Spherion					
Te marked other the traumatic event, the To Be Com	17. Fathar's Name	a (First, Middle	a, Last)			-	1 3.002		-	ıma (First, Midd					
	Leon Bryant, Sr. Thelma								Overby						
-	19a. Informant's				STANK.				and Number or F	iural Routa Num	ber, City or	Town, S	Steta, Zip C	Code)	
Item 27 Ia other tra	Leon B	ryant,	Sr./	Fathe	r	14	1620 Da	anvil.	Le Rd.	Dale Cit	zy, va	. 22.	193		
	20a. Mathod of Di	isposition 2 Cramation	n 3 🗆 🗈	amoual from		Ob. Place of cematary	Disposition (f	Nama of or othar pla	ce)	Data	20c. Loca	ation - 0	City or Tow	n, Stata	
		5 Othar		Silioval Itolii	Stata	Dumfr	cies, C	Cemet	ery	12/16/2	2000	Du	mfrie	s, VA	4
once.	21. Signature of	Euneral Service	ce Ligação	110			22. Nama	and Addr	ass of Militle	r Funera	al Hom	e ai	ad Cre	emator	У
a	1/20	tu X	Posit	telli			3200) Gol	ansky Bl	vd. Wood	dbridg	e,	VA 22	192	
an cal ner	Immediata Cause disease or condit rasulting in death	a (Final	ist only one	a causa on	aach lina. RTENSI	VE ATHE		OTIC C	ng, such as cerdi				10	Approximata ntarval Batwo Onsat and De	een eath
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month MIC Dec 11054 av 2000 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Silver 5 Gateshead Manor Dring mont Joaner 4 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) Months Days Hours 22 Yrs. 219-15-2903 DC Nov Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3422 Gateshead Manor Way 20904 USA 12. Was Decedent Ever In U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Technical Support Computer Industry 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumame) Richard J. Burke Jeanette R. Davey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette R. Burke / Mother 1022 Hollywood Avenue, Silver Spring, MD 20904 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/19/00 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Servica Licanser 22. Name end Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting in death) Due to (or as e consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 🗆 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

Depertment of Important: If any injury or

Physician

/Medical

Examiner

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Director

28a-f show

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7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Exampler must be notified at

nit. Pages 1 end 2 should be filed within 72 hours efter death vertinent of Health and Mentel Hygiene.
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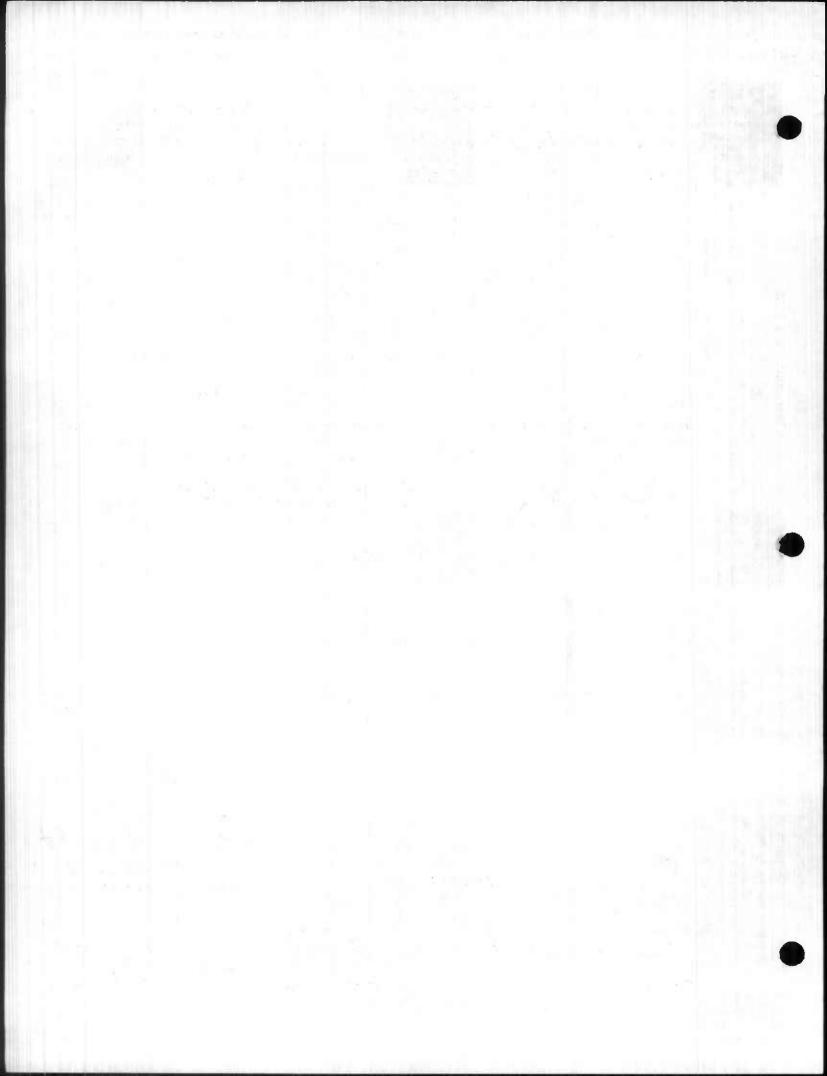
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Registrar

Attanding Physician: The law requires thet the death certificate be executed P.O. Box 68760, the signed by t Division of Vital Records, peen pege 2 s certificete this After death. i or Attendi efter death Director: A To the Hospital of within 24 hours of To the Funeral Di completely filled in

25. Was case referred to medical examiner? examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Injury AM 1 Netural 5 Pending 5elfInflict Investigation 1 Yes 2 No 2 ☐ Accident 8 18 2000 3 Sulcide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 3 4 2 3 3422 CARON Gal an Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) and menner as steted.

Medical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and plece, end due to the ceuse(s) end menner stated. 29a. Certifier (Check only one) 29b. Sonature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) NO042 TM DME 2101 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) BR HEX MD DME 31. Date filed (Month, Day, Year) 32. Registrar's Signeture DEC 2 0 2000



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16		00. Name end eddress of parties who co	unpleted cause	of death (It-	n 23e\ /Time /	Orin*\	D	003328	70	Dec,	14, 2	000
nus	-	0					ue	Cumberl	and MD	21502		
State	3	DEC 1 5 2000		gistrer's Signa		loa						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 10 2000 MARGARET K. BLOOM 11:30 pm 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Cumberland Memorial Hospital & Medical Center Allegany 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax Birthplace (State or Foreign Country) Deys 1 □ M 2 X F Yrs. 84 214-07-6072 9.1916WEST VIRGINIA 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ALLEGANY CORRIGANVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10601 KREIGBAUM RD NW 21525 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) CLERICAL WORKER FIBER/TEXTILE 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) CHARLES EDWARD KNIERIEM EDNA LLEWELLYN 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER MILLER-NIECE 19411 LOWER CONSOL RD., FROSTBURG, MD21532 20b. Plece of Disposition (Neme of cametery, cremetory or other placa) GARDENSO 20e. Method of Disposition 20c. Location - City or Town, Stete REST LAWN MEMORIAE 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State LAVALE, MD 4 ☐ Donetion 5 ☐ Other (Specify) HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Batween Onset end Death Immediate Cause (Final disease or condition rasulting in death) . Acute renal failure days Due to (or es e consequence of): 2 days b Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaese or injury Due to (or es e consequence of): that initiated events resulting in death) Lest Due to (or es e consequence of): 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 VNo 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 27. Mannar of Death 28d. Describe how injury occurred 28c. Injury et Work?

Physician /Medical Examiner

Examine

Physician/Medical

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Completed

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Certification:

Medical

1 Neturel

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Physician

/Medical

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requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Pi 124 hours after deeth.
 Funeral Director: After the letely filled in by the funeral

To the Hospital o within 24 hours aft To the Funeral Di completely filled in

nes State Registrar

31. Dete filed (Month, Day, Year) DEC 18 2000

29b. Signeture and titla of certifier

5 Pending investigation

6 ☐ Could not be determined

bushano

30. Name end address of parson who completed cause of death (Item 23a) (Type, Print) 500 MEMORIAL AVE STE 201, CUMBERLAND, MD 21502 DR ROBUSTIANO BARRERA 32. Registrer's Signetur

and menner steted.

strucy

oaks

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s)

29c. License number

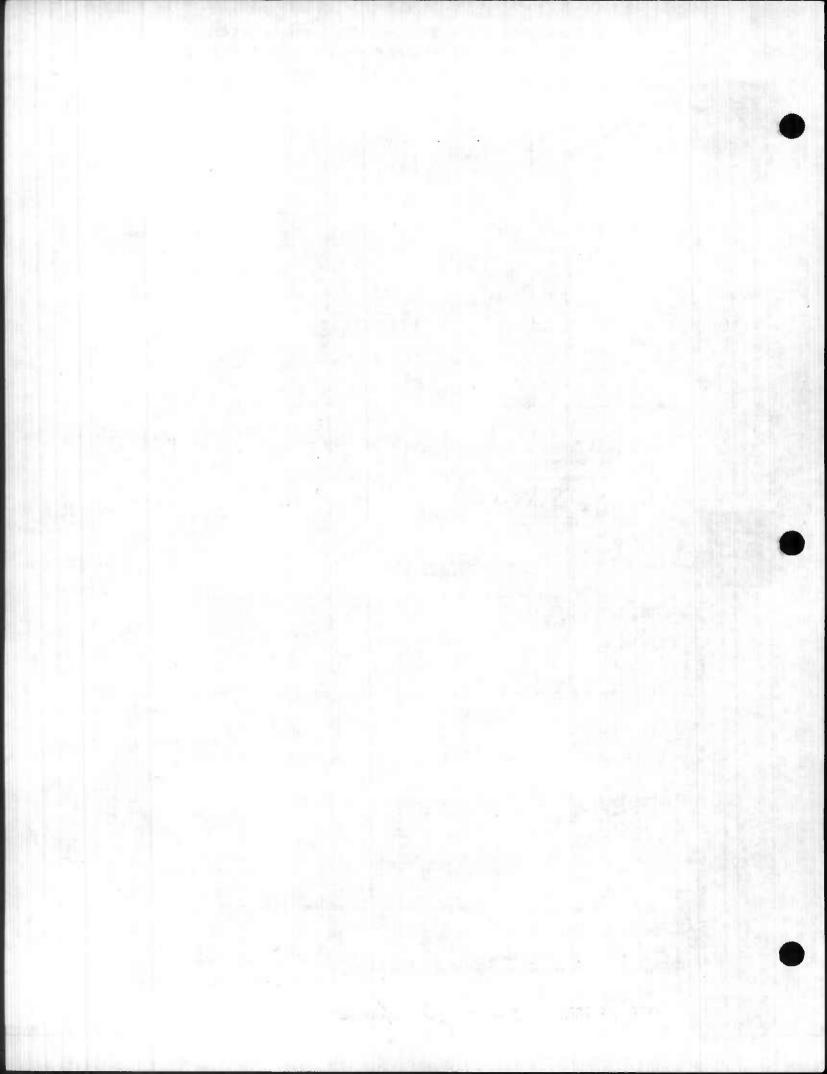
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28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

DECEMBER

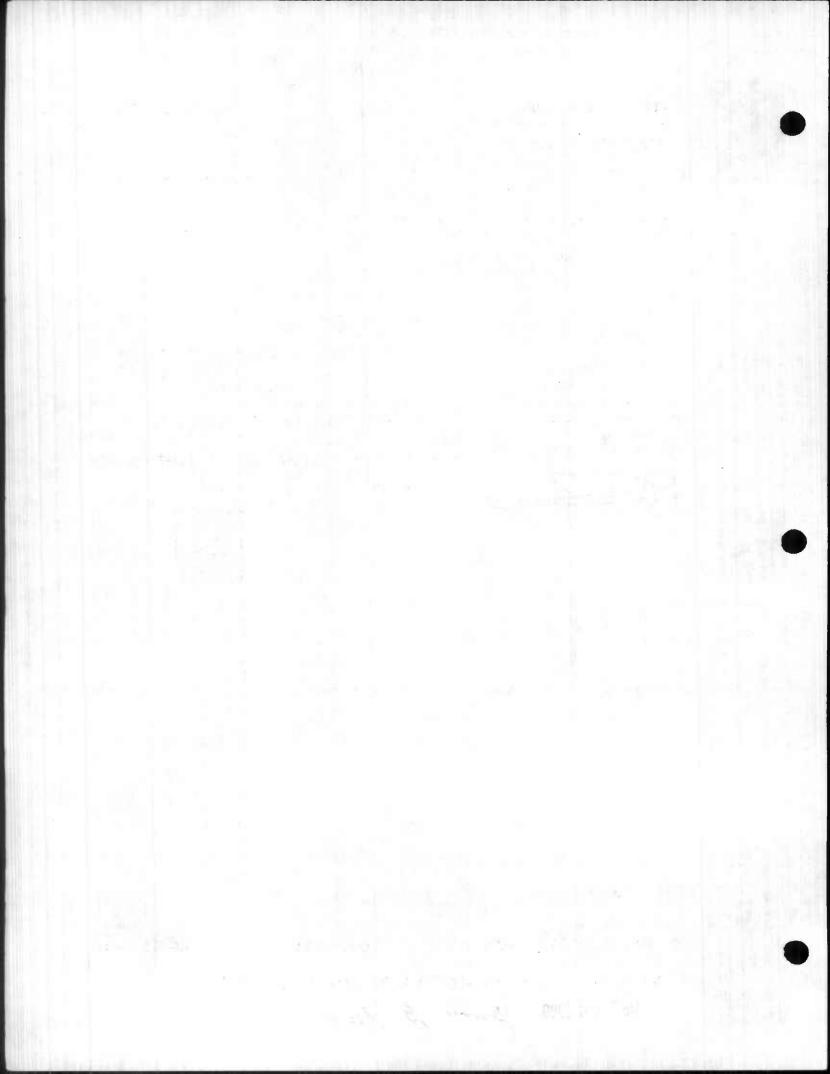
29d. Date signed (Month, Day, Year)

28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene

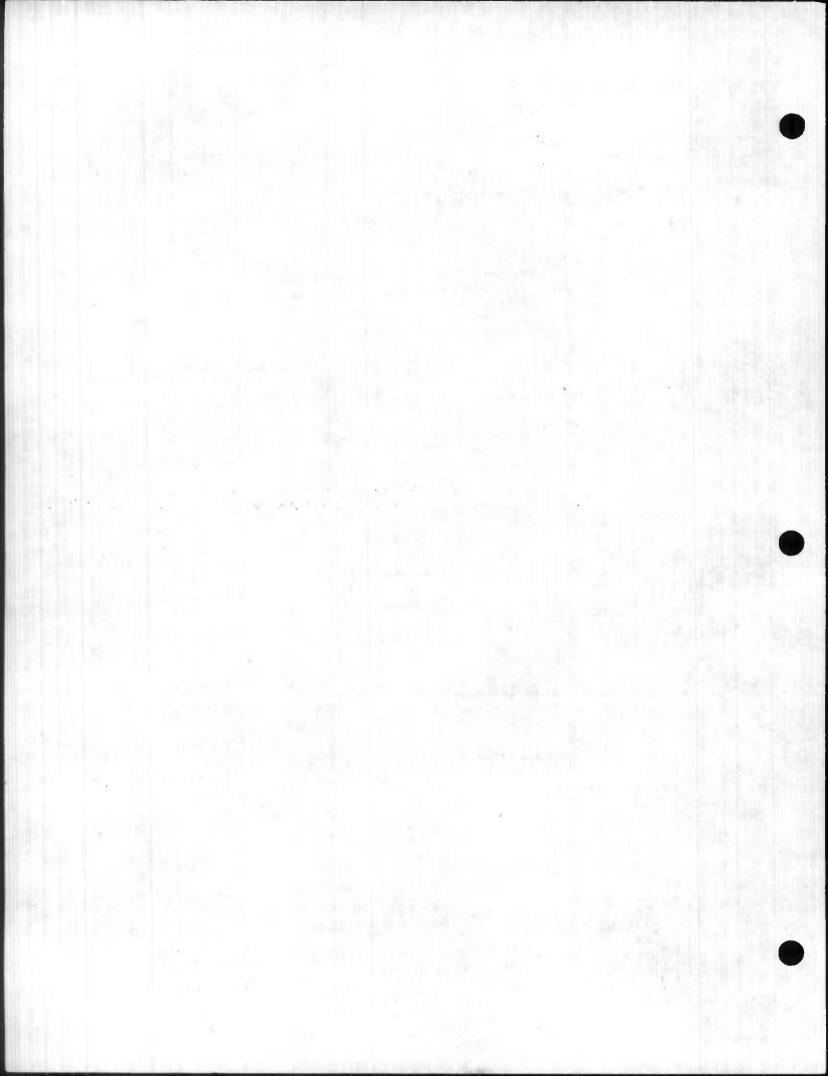
-						Ce	rtifica	ate of	Death		Reg. No.	1 42	130
Dhua	ieien		1. Decedent's Name (First, Middle, La	ist)						2. Date of De	ath Day	3. Year	Time of Death
Phys /Me	dical	_	VIVIAN SARAH	BONE						DECEMI			:03 P.M
100	niner		la. Facility Name (If not institution, gir	ve street and number	7)			4	4b. City, Town, or	r Location of Deat		ty of Death	
3			FROSTBURG VIL						FROSTB			EGANY	
Funer Direct		1		Sex 7. A 1□ M 2\ F	ge (In yrs. 91	last birthday, Yrs.	Month	der 1 Yaar ns Days	If Under 24 Hr Hours Mir		th ly, Year) 1908	9. Birthplace Country) MARYLA	(State or Foreign
anyland show		-	IOa. Stata 10b. County		10c. City	y, Town or L	ocation					10d. lr	nside City Limits
Man Fe sh	Į,	1	MARYLAND ALLEGAN	Y	F	ROSTBU	IR C					1)	X Yes 2 □ No
ith the Mi	Director		Oe. Street and Number			RODIDO		Zip Code			10g. Citizen of	What Country?	
th wil			1 KAYLOR CIRCLE					21532	2		U.S.		
items items	by Funeral	2	1. Marital Status 1 Navar Married 2 Married 3 Widowad 4 Divorcad	12. Was Decadent Armad Forces 1 ☐ Yes 2X If Yes, Give Year or Datas:	? INo		If Yas, s	pecify Cuba	ispanic Origin? (nn, Mexican, Pue Specify:	Specify Yas or Norto Rican, etc.)		ice - American In ack, Whita, etc.	
d within 72 hours af giena. Ir than "natural", or the Medical Exam	T d		15. Decedent's E	ducation		16a. Deca	ident's U	sual Occup	ation	a dela a	16b. Kind of E	Business/Industry	
C = 30	Completed		(Specify only highest grant Elementery/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	use retired	during most of we	orking			
	000		8			SPI	INNI	NG MAC	CHINE OP	ERATOR	CELA	NESE	
0 12 D	a	1	7. Fathar's Nama (First, Middla, Last						18. Mother's Na	ame (First, Middle	Maiden Suma	me)	
should be and Mental marked o	10		JOHN W. KREITZBU						SAR	AH PORTE	R		
d 2 should th and Mer 7 Is marke traumatic			19a. Informant's Name/Relationship (JOHN H. BONE / SO							Rural Route Numb		n, Stete, Zip Code))
F 2 2 7		-	Oa. Method of Disposition	IN	20h Di	2U0			L, FROS	TBURG, M			
ages nt of if it		-	1 Burial 2 □ Cremation 3 □		Ca	ametery, cre	matory o	r other plac	*	Date		- City or Town, S	tate
permit. Pages 1 ar Department of Hea mportant: If Item in Injury or other			4 ☐ Donation 5 ☐ Other (Special Service Licenses)	-	FRO					12/24/00	FROSTB	URG, MD	
permit. Pages 1 a Department of He Important: If Item any Injury or oth	buce		Division Salviga Cross	700		SC	OWER:	5 FUNE	ERAL HOM				
Physicia	n		 Part1. Enter the disaasa, or com shock, or haart failure. List only 	plications that cause one cause on each I	d tha death line.	. Do not an	tar the m	ode of dyin	g, such as cardia	OSTBURG, ac or respiratory a	MD 215	Appi	roximate val Between at and Death
/Medica Examine	_	1	mmediata Cause (Final diseasa or condition esulting in deeth)	a. Care	liop.	ulmo	nar	y a	rrest			No	t knows
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cuted	Examiner	1	Sequentially list conditions.	b. Fried		as a conse		f);				Coo	D WEEK
ificeta be exe g physician a as the burial-		i	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or Injury										
eath certificeta be executed attending physician and for use as the bunal-transit	edical	1 5	hat initiated events esulting in death) Last	C. —	Due to (or	as a consec	quenca o	f):					
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that the death c ed by the attend datached for us	Physician			u									
the de	ysic	P	art II. Other eignificent conditions of	ontributing to death b	out not resu	Iting In tha u	indertying	causa give	en in Part I.	23b. Did	lobacco uee co	ontribute to the	auge of death
that the sed by datac			Dementia	advance	ed.					1 🗆	Yes 2 No	3 Probably	4 Unknow
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2 8 8	Completed	-									an autopsy med?	avallable	ion of cause
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ysician: The s cartificate director, pag	Be		5. Was case referred to medical examiner?						26. Place of De	ath (Check only o			/\
5 00	10		1 Yes 2 No	Hospital: 1 ☐ Inpatia	ant 2 E	ER/Outpatier	nt 3 🗆 I	OOA Othe		Home 5 Resid		her (Specify)	
ding Ph. After thi funeral			7. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	Iry Iv Year)	28b. Time o	f	28c. Injury Work		28d. Describe I			
aath. or: A	catio		2 ☐ Accident investigation			,,	М		res 2□No				
after di Direct	Certification:		3 ☐ Suicide 6 ☐ Could not be determined	286. Placa of inj	jury - At hor c. (Specify)	me, farm, str	eet, facto	ory, offica		28f. Location (S City or Tox		ber or Rural Rou	e Number,
To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funeral	edical C	1	9a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o	r examinati	rledge, deeth	n occurre	d et the tim	e, date end place	a, and due to the urred at the time.	cause(s) and m	anner as stated. and due to the c	ausa(s)
within 2 To the compla	Mec	2	9b. Signature and titla of cartifier	and manner st	6 (60.			9c. Licensa					
			01	P. M.								ed (Month, Day, 1	ear)
E,			Nonsocks					V 00 5	5325		vec 2	3,2000	
6			D. Name end address of person who					-	.11	.40 -14-			
		-	VONSOCK SHIN MD	48 Tarm Te			2 204	11-0	stowing,	MD 215	32		
S	tate	3	DFC 2 6 20	32. Registr	ars Signati	ure /		1					



hysician	Decedent's Neme (First, Middle, Last	it)		ftificate of		2. Deta of Deeth Month	Dey	Yeer	of Death	
/Medical	Donald Charles				4b. City, Town, or L	DECEMBER			A/M.	
xaminer	4a Fecility Nema (If not institution, give FRANKLIN SOUARE HC				ESSEX	OCALIOTI OI DOGIN	4c. County of Deeth BALTIMORE			
neral ector	Social Security Number 6. Security Number		yrs. last birthday) Yrs.	If Under 1 Yea Months Day	If Undar 24 Hrs.	8. Date of Birth (Month, Day, Jan. 8,	Year)	9. Birthplaca (State Country) Englar	a o <i>r Foraign</i>	
	Usual Residence of Decedent 10a. Stete 10b. County	10	c. City, Town or Lo	ocation				10d. fnside		
notfled at		5-110-0 PM							es 200 No	
be notthes Director	Maryland Harf	ord	3(oppatown 10f. Zip Code		10	g. Citizen of V	What Country?		
	540 B Riviera Dri	.ve		210	85	3 4 4	U.	S. A.		
nome 234	11. Maritel Stetus	12. Wes Decedent Ever Armed Forces?	r in U,S. 13.	Was Decedent of	Hispanic Origin? (Sp ben, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - American Indien, ck, White, etc.	- T II	
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Giva		1□ Yas 2NN			Specify	" White		
ed b	15. Decedent's Ed	Yeer or Detes:	16e. Dece	dent's Usual Occ	upetion	1	6b. Kind of Bu	usiness/industry		
n, the Mexical	(Specify only highest gra- Elemantary/Secondary (0-12)		(Give	kind of work don DO NOT use reti	e during most of wor	king				
Comp	4th Grade			Sales				utomotive		
event,	17. Fathar's Nema (First, Middla, Last)					na (First, Middle, M	faiden Sumaπ	na)		
aumatic	Donald D. Cook	Sura Dainel	10h Mail	in a Autoron (Chro	Dori et and Number or Ru	s Cant	City or Town	State Zie Code)		
	19e. Informant's Neme/Reletionship (1) David Cook (Broth		115		gate Rd,					
other tr	20e. Method of Disposition		Ob. Place of Dispe	osition (Name of				City or Town, Stata		
	1 ☑ Buriel 2 ☐ Crametion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify			Mamoria	1 Gardens	12/30/00	Raltim	ore Mary	1 and	
mportant: If any injury or ansa.	21. Signature of Funeral Service Licen	() (2. Name end Add		12/30/00	Dartin	ore, mary	Tand	
558	W Wrishmai	Ahund			Funeral				014	
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and I-transit Xamlr	Sequentially list conditions,	b. Due	to (or es e conse	quence of):						
buria BI	Sequentially list conditions, if any, leading to immediate cause. Enter Undarfying Cause (Disease or Injury that initiated quents	c								
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for use as the bur	that initiated events	cDue	to (or es a consec	quance of):	given in Pert I.	23b. Did to	bacco use co	ntribute to the cause	se of death?	
by the attending physical ached for use as the bur thy sician/Medical	Cause (Disease or injury that initiated events resulting in deeth) Lest	cDue	to (or es a consec	quance of):	given in Pert I.			ntribute to the cauc		
d by the arending physicial let and for use as the but	Cause (Disease or injury that initiated events resulting in deeth) Lest	cDue	to (or es a consec	quance of):	given in Pert I.	1 🗆 Ye	98 2□ No	3 Probably 4	Unknown	
Physician/Medical	Cause (Disease or injury that initiated events resulting in deeth) Lest	cDue	to (or es a consec	quance of):	given in Pert I.		autopsy	3 Probably 4 24b. Were autop aveilable pri completion	Unknown Sy findings or to	
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ns certificate has been signed by the attending physical director, page 2 should be detached for use as the bur To Be Completed by Physician/Medical	Pert II. Other significant conditions of axaminar? 1 ∑Yas 2 □ No 27. Manner of Deeth	cDue d ontributing to death but no	ot (or es a consection of resulting in the use of the consection o	underlying cause	26. Place of Dec Dther: 4 ☐ Nursing H	24e. Wes er perform Ye ath (Check only one one 5 Reside 28d. Dascribe ho	n autopsy ned?	24b. Were autop aveilable pri completion of deeth?	Unknown sy findings or to of cause	
ns certificate has been signed by the attending physical director, page 2 should be detached for use as the bur To Be Completed by Physician/Medical	Pert II. Other significant conditions on axaminar? 1 □ Yas 2 □ No	cDue d ontributing to death but not Hospital: 1 N Inpatiant 28a. Dete of Injury 1 North Day Ye	ot (or es a consection of resulting in the use of the consection o	quance of): underlying cause and a point a DOA of 28c. In W	26. Place of Dec Dther: 4 ☐ Nursing H	24e. Wes er perform Ye eth (Check only one one 5 Reside	n autopsy ned?	3 ☐ Probably 4 24b. Were autop aveilable pri completion of deeth? Yas 2 ner (Specify)	Unknown sy findings or to of cause	
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DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth 19,2000 3:31pm Teresa Cruz December 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplaca (State or Foreign (Month, Day, Yeer) 9.14 El Salvador 5. Social Security Number 7. Age (In yrs. lest birthday) 1□M 2X F Months Deys Hours 86 Yrs. 213-29-8694 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Germantown 1 X Yes 2 □ No Montgomery 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code El Salvador 20876 11717 Zebrawood Court 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Race - American Indian, Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 ☐ Married Specify: Hispanic 1 X Yes 2 No SpecifEl Salvador 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker none 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Marta Ramos Matilde Cruz 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Sandra Contreras/Niece 11717 Zebrawood Court Germantown, Md. 20876 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removel from State Gate of Heaven Cem 12/23/00 Silver Spring, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of uneral Service License 22. Name end Address of Fecility Philip D.Rinaldi Funeral Service 11818 New Hampshire Ave.Silver Spring, Md 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Final 1 day disease or condition resulting in deeth) Septic Shock Due to (or es a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): that initiated events resulting in deeth) Lest Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes No 3 Probably 4 Unknown Gastro intestinal hemorrhage, hypertension, 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

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Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Mapical Examiner maint be notified at

the Marylenc

with

72 hours efter

oe filed within 7 al Hyglene.

12 should be fill h end Mental H 'is marked oth

permit. Pages 1 and 2 Department of Health e Important: If frem 27 is any injury or other tree

Maryland 21215-0020

Baltimore,

Box 68760 certificate be

P.O.

Records,

Division of Vital

Examiner physician and s the bunal-transit Physician/Medical 88 980 Po signed by the e 2 Completed funeral director, Be 10 Certification:

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i or Attendent efter deet Director:

To the Hosp within 24 ho To the Fune completely fi

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filled in t Hospital 24 hours e Funeral D

Medicai

multi-infarct dimentia 25. Wes case referred to medical examiner? Hospital: 1√ Inpatient 2 ER/Outpetient 3 DOA

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be 28e. Dete of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

Location (Street end Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signeture end title of certifier

29a. Certifier

1 Neturel

2 ☐ Accident

3 Suicide

10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29c. License number 29d. Date signed (Month, Dey, Year)

26. Place of Deeth (Check only one)

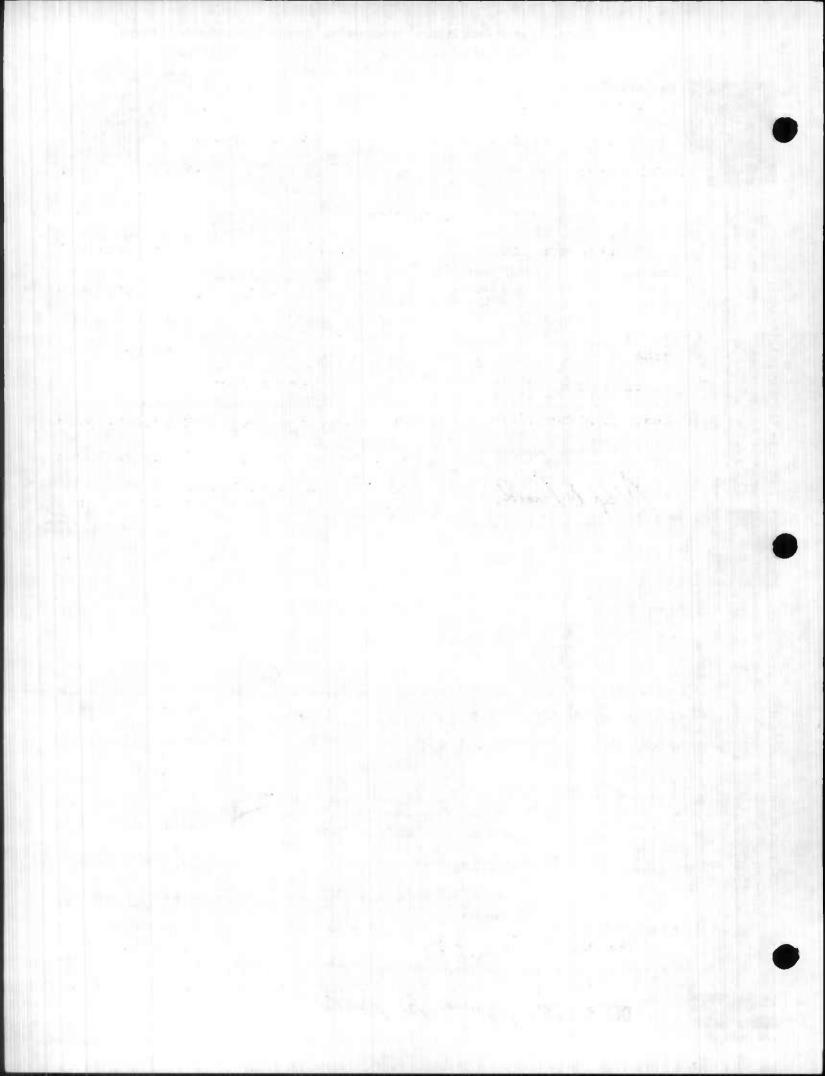
D08944

Dec.20,2000

30. Name end eddress of person who completed cause of beath (Item 23e) (Type, Print)

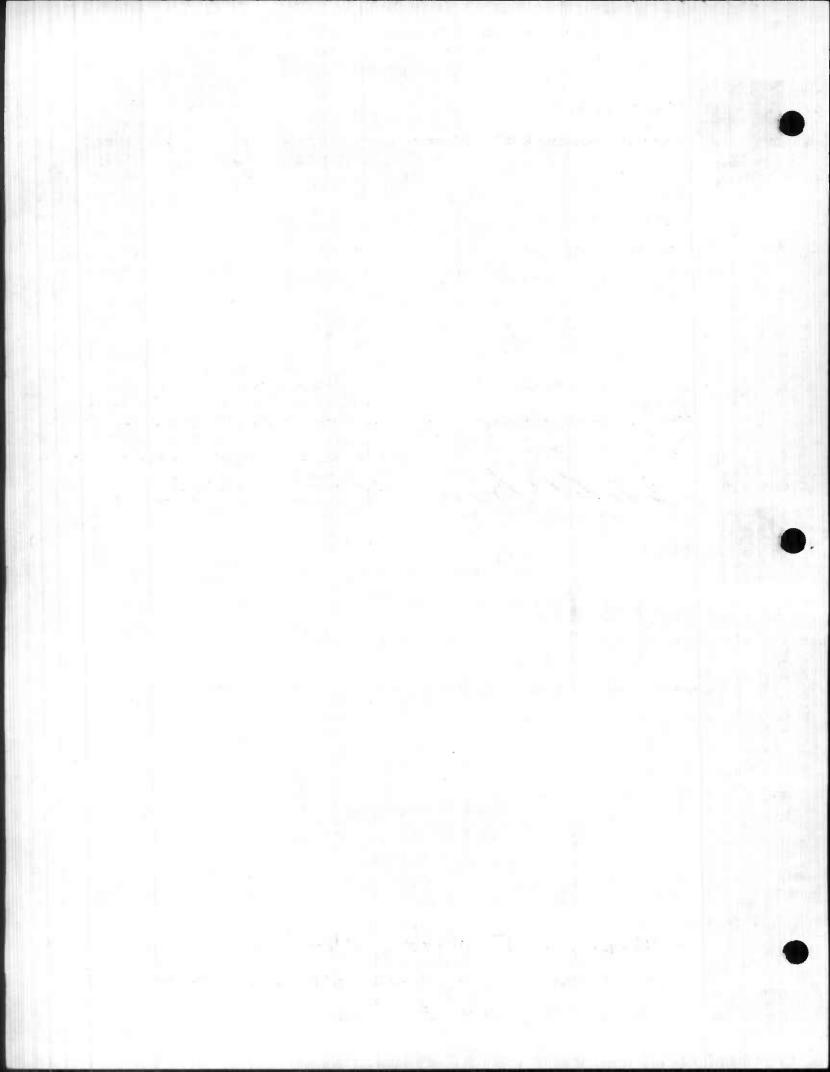
Martin C, Shargel, M.D. 3720 Farragut Ave. Kensington, Md 20895-2110

State Registrar 31. Date filed (Month, Day, Yeer) DEC 2 2 2000 32 Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 0 42133

					C	ertifica	te of	Death		Reg. No.	0 4	6	33	
Characteries		1. Decedent's Name (First, Middle, La	ıst)						2. Date of De	ath	V	3. Time	e of Death	
Physician /Medical	_	Theodus R. Conn	er						Decemb	er 16,	2000	2:0	MA O	
Examiner		la. Facility Name (If not institution, given	ve street and numb	ber)				4b. City, Town, o	r Location of Death	4c. Coun	ty of Death		-	
	ı	Manor Care Nursi	ng & Reh	abilit	tatio	n Cent	er	Chevy (Chase	Mon	tgomer	*V		
neral ector		5. Social Security Number 6. S		Age (In yrs.	last birthd	ay) If Und	er 1 Year	If Under 24 Hi	8. Date of Birt	h v. Year)	9. Birthp	lace (State	te or Forei	
	1	Usual Residence of Decedent 10a. State 10b. County			ty, Town o	Location			March	3,1900		nsas	City Llmlt	
r 28a-f show		Maryland Montgom	nery		evy C								es 2 N	
23a or 2		8700 Jones Mill	Road				ip Code 0815			10g. Citizen of Whet Country? United States				
ramner m	1	1. Marital Status 1 □ Never Married 2 □ Married 3 ሺ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	es? □No 19		3. Was Dec If Yes, sp	**		Specify Yes or No- rto Rican, etc.)	14. Re Bl	ace - Americack, White, o	etc.		
valcal Exp		15. Decedent's Ed	ducetion		16a. De	cedent's Us	ual Occu	pation		16b. Kind of				
other traumatic event, the Mudical E	-	(Specify only highest gra Elementary/Secondery (0-12)	College (1-4	or 5+)		e. DO NOT sician		pation during most of w ed)	orking	Medi	c a 1			
e out		7. Fether's Name (First, Middle, Last,)		1 - 119	Jeoran		18. Mother's Na	ame (First, Middle,					
To Be Comp		David Alexander (Conner						Belle (r			2)		
mati		19a. Informant's Name/Relationship (19h M	ailing Addres	e (Strop		Rural Route Number					
ta		Edith W. Tucci, g		or					#1401E,C				015	
any Injury or other traum once.		0a. Method of Disposition		20b. F	Pleca of Di	sposition (Ne crematory or	eme of		Date	20c. Location	-			
ury		4 □ Donetion 5 □ Other (Specif		Ft	Li:	nco1n	Ceme	tery	12/21/00	Bren	twood,	Mar	yland	
any Injury once.	2	21. Signature of Funeral Service Upon	1889/1/5	11		McGuir	e Fu		rvice, I					
	-	Part1. Enter the disease, or com	plications that say	and the deal	b. Do not	7400 G	eorg	ia Ave.	N.W., Wa	shingt	on, D.			
ician	1	snock, or neart failure. List only	one ceuse on eac	h line.	n. Do not	enter the mo	de or dy	ng, such as cerdi	ac or respiretory ar	rest,		Approxim Interval E Onset an	Between	
dical niner	1	mmediate Cause (Final disease or condition	Pneum	nonia							_ 1	l wee	k	
		esulting in death)		Due to (d	or as a con	sequence of):							
ir sit			h								1			
inel-transit		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (c	or as a con	sequence of	H:							
He bu	t	Cause (Disease or Injury het initiated events esulting in deeth) Last	C. —	Due to (o	r es e cons	sequence of)	:							
for use as the buriel-transit clan/Medical Examir		L	d											
atached for u	-	ant II. Other classificant conditions												
schex 1ys		ert II. Other significant conditions of	ontributing to death	n but not res	ulting in the	underlying	ceuse gi	ven in Part I.		obacco use c				
90 3	-	Metastatic Pro	state Ca	rcino	ma				101	'es 2□No	3 □ Prob	ably 4	Unknow	
2 should pleted	-	Congestive Hea	ırt Failu	re					24a. Was a perfor	an autopsy med?	ava	ere autops ailable pric apletion o death?		
rector, page									1 🗆 Y	es 257 No	1□	Yes 2	□ No	
Be Be		5. Was cese referred to medical exeminer?						26. Place of De	eth (Check only or	ne)				
P 5		1 Yes 2 No	Hospital: 1 ☐ Inpe	atient 2	ER/Outpat	ient 3 D	OA Oth	ner: 4 Nursing	Home 5 ☐ Resid	ence 6 🗆 Ot	her (Specify	,)		
	2	7. Manner of Death 1. Naturel 5 Pending 2. Accident investigation			28b. Time Injur		28c. Inju		28d. Describe h			,		
ed In by the funara Certification:		2 Accident 3 Suicide 4 Homicide	28e. Place of	Injury - At ho etc. (Specif)	ome, farm,				28f. Location (S City or Tow		ber or Rural	Route No	ım <i>ber</i> ,	
Completely filled In b.	2	9a. Certifier (Check only one) 1 ☐ Certifying Physics 2 ☐ Medicel Example	ysician: To the bealiner: On the basis and manner	or examinal	wledge, de tion and/or	ath occurred Investigation	at the tin	me, dete and piec pinion, death occ	e, end due to the c urred at the time, o	ause(s) and mate and place	nanner as sta , end due to	ated. the cause	∋(s)	
Me	2	9b. Signature end title of certifier			^	29	c. Licens	e number	_ 2	9d. Date sign	ed (Month, E	Day, Year)	
		· Wilkmin	~ J	· Ni	nals	2	DL	+528	5	Decer				
	30). Name and address of person who o	completed cause o	of death (Item	23a) (Typ	e, Print)								
	1	Wilkinson J. Nina	la, M.D.	, 344	Univ	ersity	Bou	levard,	Silver S	pring.	MD 20	901		
State		1. Date filed (Month, Day, Year)	32. Regi	strar's Signa		-								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** December 12, 2000 7:25pm Ellen Adeline Conner /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Brook Grove Rehab. and Nursing Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, OCT 3, 9. Birthplace (State or Foreign Country) Pennsylvania 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 28 F 80 Yrs. Director 171-22-0686 Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23e or 28e-f show traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director Sandy Spring Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with United States 20860 18131 Slade School Rd. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "naturel", or ther any injury or other traumetic event, the Medical Examina-1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Restaurant Etementery/Secondary (0-12) Cottege (1-4or 5+) Cook 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Ella Mae Deemer Cloris Kerr 0 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 9304 Emory Grove Rd., Gaithersburg, MD 20877 Susan Conner / Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dec 16 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Beltsville, MD 2000 4 □ Donetion 5 □ Other (Specify) Chesapeake Crematory 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Rapp Funeral & Cremation Services Silver Spring, MD 933 Gist Ave. halle 23e. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final ASPIRATION PNEUMONIA disease or condition resulting in death) Examiner Due to (or es e consequence of): DysPHAGIA

Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest and physician a s tha burial MULTIPLE CEREBRAL Box 68760 Physician/Medical attending P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records. þ 24b. Were eutopsy findings eveilable prior to 24a. Was en eutopsy performed? Completed been : completion of cause of deeth? 1 Yes 1 ☐ Yes 2 ☐ No certificata Hospital or Attending Physician: 24 hours after death. Funeral Director: Aftar this certifics 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No funeral 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1.28 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) In by 4 - Homicide To the Hospital within 24 hours a To the Funeral Complataly filled Certifying Phyeicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29e. Certifier Medicai 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) m STAFPHY SICIAN December 14, 2000 30. Name end eddress of person who completed cause of death (ttem 23e) (Type, Print) 18100 Stade School Load Sandy Spring, Maryland 20860 GRACE BROOKE HUFFMAN, MID

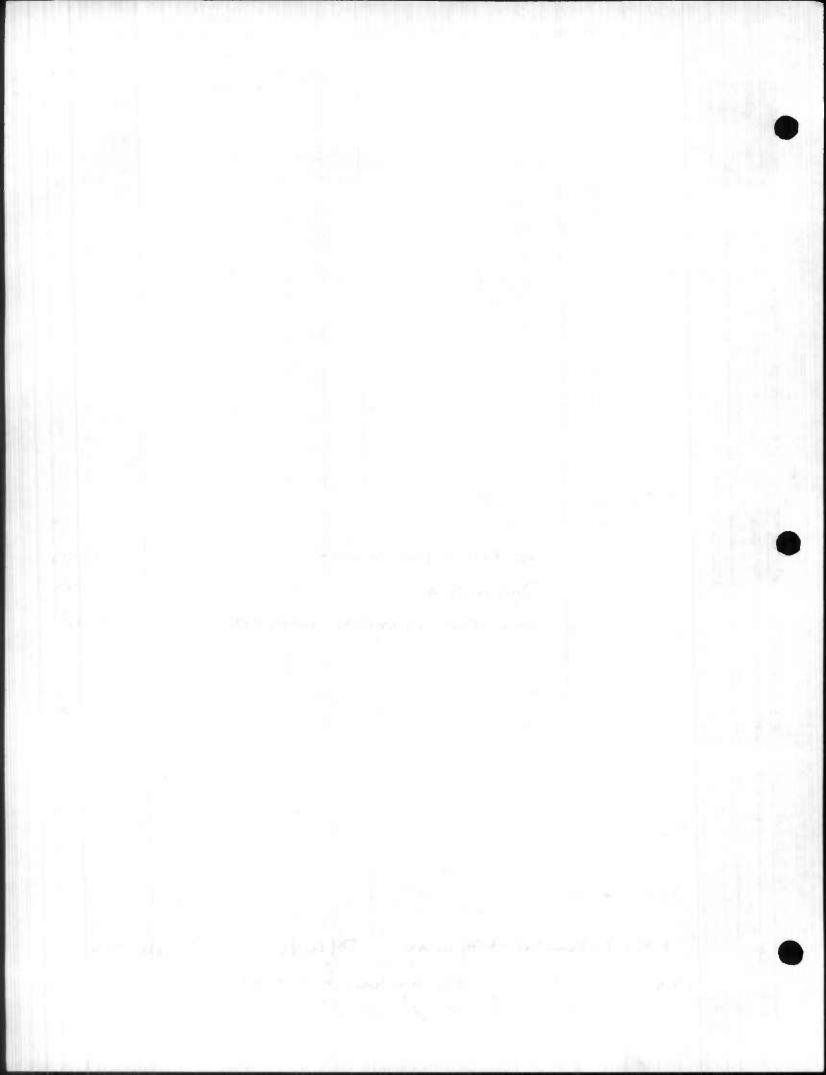
32. Régistrer's Signature

1 9 2000

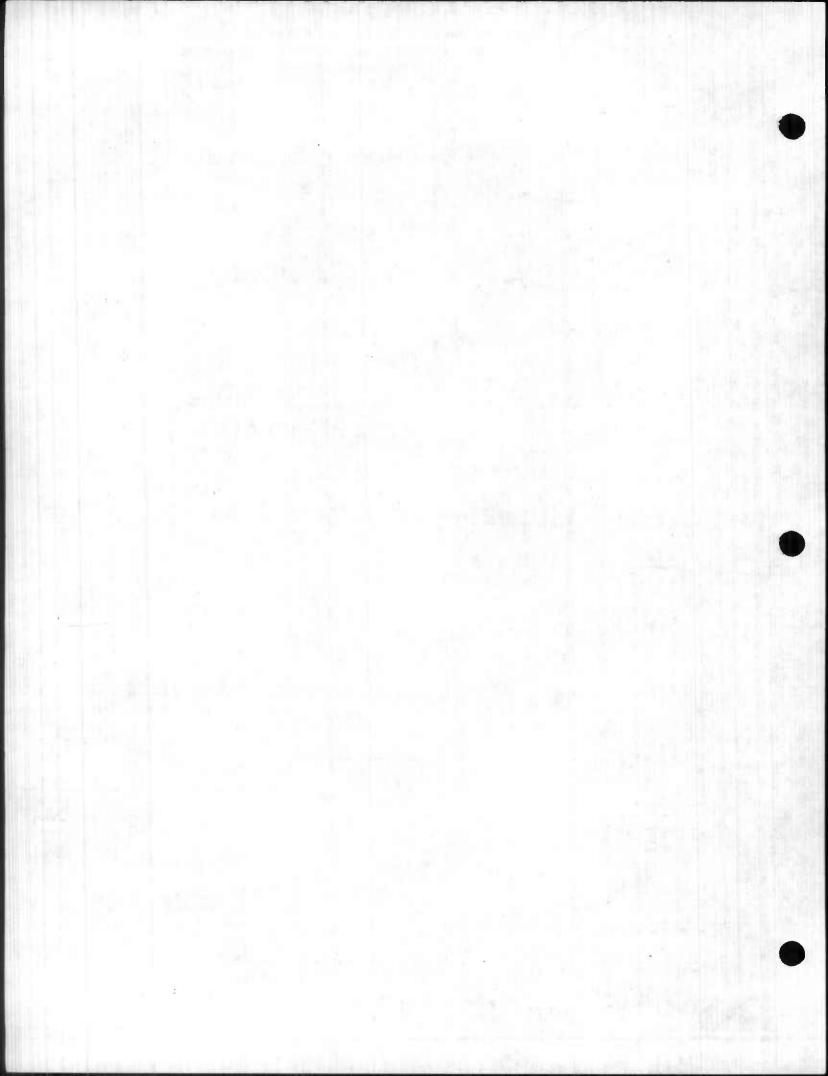
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Registrar

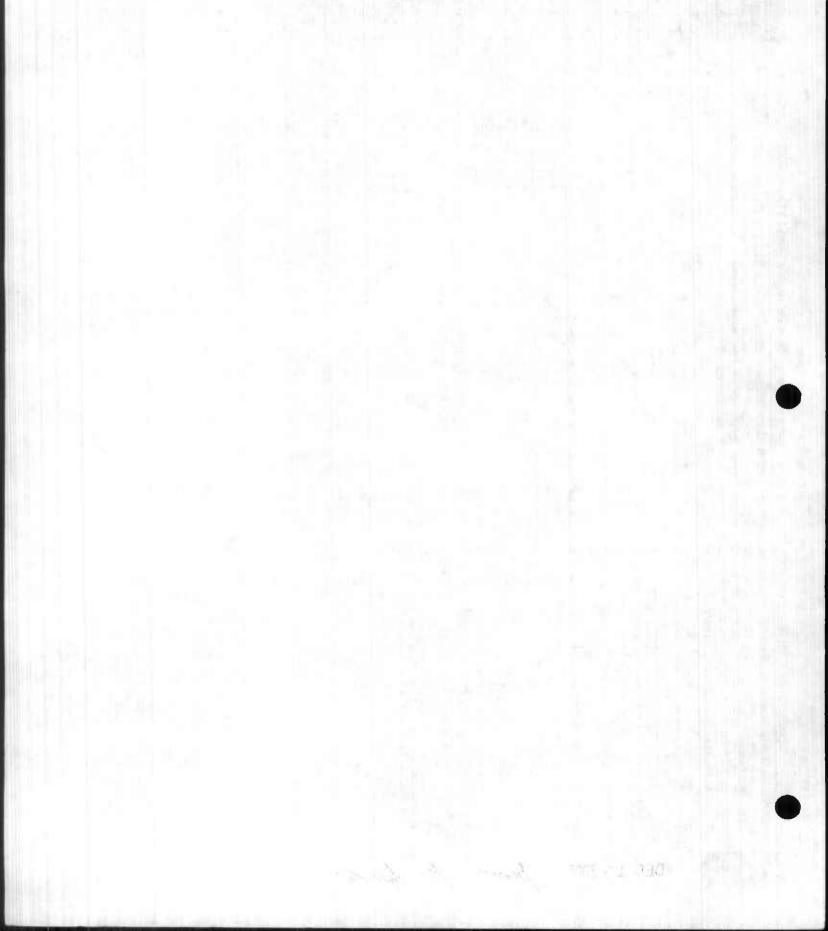


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death Day Month Year **Physician** Sun Hui Chung December 18, 2000 7:12 pm /Medical 4a Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 10905 Brent Road Potomac Montgomery 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 10M 20F Months Hours 86 Director 1914 147-66-8627 Korea Usual Residence of Decedant the Menylend 10c. City, Town or Location 10a Stata 10h County 10d Inside City Limits must be notified at 1 Yas 2 No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 10916 Burbank Drive Funeral i Hygiene, other than "natural", or flams 23 went, the Medical Examiner mas 20854 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0036 Specify: Asian p 3 ₩idowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry filled within Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 Own Home permit. Pages 1 and 2 should be tile.
Department of Health and Mental Hygi
Important: If Nen 27 is marked other
any Injury or other traumented other 18. Mothar's Name (First, Middla, Maidan Surnama) 17. Fathar's Name (First, Middla, Last) Be 9 Soyu Chun Sun Lee 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 10916 Burbank Drive, Potomac, MD 20854 Doo H. Chung/ Son 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Date 4 ☐ Donation 5 ☐ Othar (Specify) Norbeck Memorial Park 12/22/00 Olney, MD 21. Signeture Th Funaral Service Licenses 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrast, interval Batween chosen, or heart failure. List only one cause on each line. MD20901 **Physician** /Medical Immediate Causa (Final diseasa or condition rasulting in daath) a Acute Congestive Heart Failure Examiner Dua to (or as a consaquance of): Examiner Renal Failure physician and the burial-trensit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants rasulting in death) Last Dua to (or as a consequance of): Records, P.O. Box 68760, c. Pneumonia Physician/Medicai Dua to (or as e consequance of): 88 for use as Hypertension signed by the a 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to should should Completed 24a. Was an autopsy completion of causa of daath? is certificate hes director, pege 2 1 Yas 2 No 1 Yas 2 No Division of Vitai 25. Was casa refarred to medical examiner? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidance 6 Mother (Specify) residence To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2N No After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 1 A Natural 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Hospital or Attending 5 Panding invastigation 1 ☐ Yas 2 ☐ No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide in 24 hour. The Funeral Dis-28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 4 Homicida 🖔 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated. edicai 29a. Cartifiar To the Hosp within 24 ho To the Fune completely fi 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. (Check only one) 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signeture end titla of certifian D 14905 Decmeber 21, 2000 NMM. 30. Nama and addrass of person who complated causa of daeth (Item 23a) (Type, Print) Year-Kwon H. Yoon, MD 7307 Baltimore Ave., Suite #111, CollegePark, MD 20740 DEC 2 2 31. Data filed (Month, 32. Régistrer's Signature State souls Registrar



State of Maryland / Department of Health and Mental Hygiene 0 42136

							Ce	rtifica	te of	Death			Reg. No.			
			1. Decedent's Neme	(First, Middle, La	ist)				JI F			2. Date of Dec Month		Year	3. Tim	e of Death
	Physicia	_	HAZEL	A. CO	Y							DECEMBE	R 11,20		4:4	0 PM
	/Medica Examine		4a Facility Neme (If			m <i>ber</i>)				4b. City, To	wn, or Lo	ocation of Deeth				- 7-4
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-				SQUARE 6.5			EK s. lest birthday	a If Unde	er 1 Year	ROSE If Under						to as Familian
1	Funeral		5. Social Security No		M 2√DF	7. Age (III yis		Months		Hours	Min.	8. Date of Birt (Month, Da NOV . 28	Y, Year)	Cour	itry)	ate or Foreign
н	Director		213-36-9	067			113.					NOV. 28	1,1939	WEST	VIR	GINIA
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	deeth with the Meryland ms 23a or 28a-f show irrust be notified at	Funeral Director	MD MD	BALTIM	ORE		LTIMOR									Yes 2∏ No
	r 28a-f	9	10e. Street and Nun	nber				10f. Z	ip Code				10g. Citizen of	What Cour	ntry?	
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	eett eett	era	11. Meritel Stetus		12. Was Dec	edent Ever in	U.S. 13.	Was Dec	edent of H	lispanic Ori	ain? (Sp	ecify Yes or No		ce - Americ	en India	n,
		5	1 ☐ Never Merrie	ad 2 Merried	Armed Fo	orces?		If Yes, sp	ecify Cuba	an, Mexicen	, Puerto	Rican, etc.)	Bla	ick, White,	etc.	
5-0020	urs e	P	3 Widowed		If Yes, Gi Year or D	ve 21		1 ☐ Yes	2]X] No	Specify:			Specia	v: WHI	TE	
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		Be C	17. Father's Name ()					18. Mothe	r's Nam	e (First, Middle,	Maiden Sumai	ne)		
Maryland	id be ente ked ic ev	0	EMMETT F	ESNER						N	ORA	LEASE				
5	M bu	-	19a. Informant's Na	me/Relationship	Type, Print)		19b. Mail	ing Addre	ss (Street	and Numbe	er or Run	al Route Numbe	or. City or Town	. State. Zic	Code)	
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	of Health Nem 27 Cother t	+	20e. Method of Disp		214	20h	Plece of Disp			LTATE!	DALLI	Date Date	20c. Location		wn Stat	
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ait	permit. Pe Departmen Important: Iny Injury	1	21. Signeture of Fur	neral Service Lice	nsee					ss of Facilit						
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		-	23a Part1 Enter th	disease or com	nlications that	caused the dec	eth. Do not en	202 G	REENI	E STRI	Cerdiac	CUMBER	LAND, M	D 21	502 Approxi	imate
			23a. Part1. Enter the shock, or hear	t feilure. List only	one ceuse on e	ech line.	Our. 50 Hot 0.			·g, occircae		or recognition,			Interval	Between and Death
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н	a	3	resulting in deeth)			Due to	(or as a conse	quence of):						0	
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	icete be executed physicien end s the buriel-trensit	Examiner	Sequentially list conditions, Due to (or as a consequence of):													
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Ρ.	as that the death cer gned by the attendir be datached for use	Physician										×	Yss 2□ No	3 Pro	bably	4 Unknown
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0	ath.	ĕ	2 Accident	investigatio	n			М		Yes 2	No					
Division	Attending r death. ector: After by the fune	Certification:	3 ☐ Suicide	6 Could not b	286. Place	of Injury - At	home, farm, s	treet, facto	ry, office			28f. Location (ber or Run	al Route	Number,
á	after Direct	E	4 Homicide		build	ing, etc. (Spec	city)					City or To	vn, State)			
	ours filler		29a. Certifier	Certifying Pr	velclen: To the	heet of my kr	nowledge dee	th occurre	d at the tir	me date an	d place	and due to the	cause(s) and m	anner as c	tated	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical		2 Medical Exa	niner: On the b											ise(s)
	To the To the comple	Š	29b. Signature/and	title of Certifier	and man	otatou.		2	9c. Licens	e number			29d. Date sign	ed (Month	Dav. Ya	ar)
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			30. Neme and addre	ss of person who	completed ceu	se of death (Ite	em 23e) (Type	Print)	. (×		Baltin		1-	021	20
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 930 AM Month Year **Physician** Robert 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1♥M 2□F Dec. 10 1927 Director 235-38-2965 West Virginia Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 XYes 2 No Directo Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be a 20901 414 Royalton Road United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 (∑) Yes 2 □ No If Yes, Give Yeer or Detes 1 945 – 1947 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 Yes 2 No Specify: Specify: py 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) World Bank filed within Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) Assistant Secretary for Conferences 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be and Mental h and Mental Callis Thomas Harrison Mary Chole Sommerfield 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) permit. Pages 1 and 2 at Department of Health and Important: If New 27 is n any injury or other traus Barbara A. Callis/Wife 414 Royalton Road, Silver Spring, MD 20901 Saltimore. 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Dec. 22 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc 2000 Beltsville, MD 22. Nome end Address of Facility Rapp Funeral & Cremation Serv. Stephen D. Lohrmann, PA 933 Gist Ave. Silver Spring, MD 20910 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuselon each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Examiner Coronery cutery Dyers After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burlai-transit certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as e consequenca of): The law requires that the death Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Chronic obstricte planey disease by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 No 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 1 Destural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred ipital or Attanding Pi curs after death. neral Director: After t y filled in by the funer Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 35+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avene Silver Spring mo 209 02 10313 GEOTIZ Michael mo. Lincoln

State Registrar

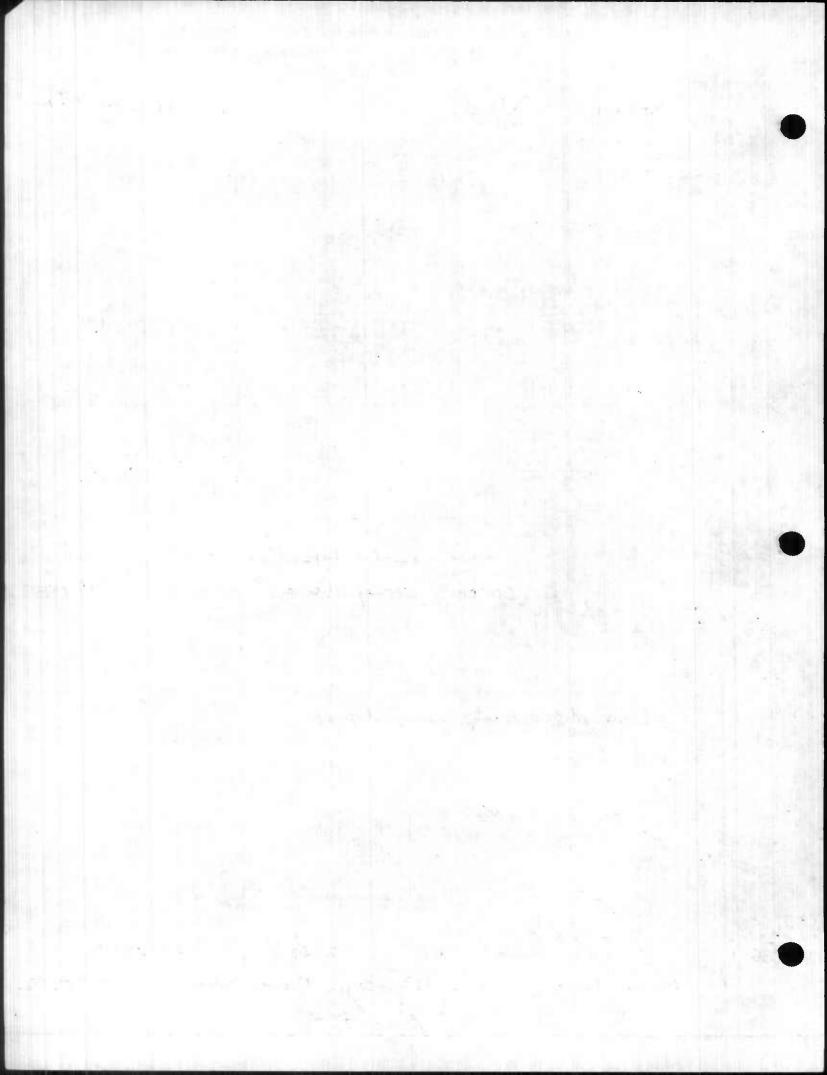
31. Dete filed (Month, Day, Year)

DEC 22

2000

oorke

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Yee John Chapman 2230 hrs December 13, 2000 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Collingswood Nursing Center Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 10XM 2□ F Yrs. 165-18-7371 93 May 13, 1907 Pennsylvania Usual Residence of Decadent 10b County 10c. City. Town or Location 10d. Inside City Limits 1 No Yes 2 No Maryland Montgomery Gaithersburg 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Counfry? 9201 Edgewood Drive 20877 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 □ Never Merried 2 □ Married 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorcad 16e. Decadant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decadant's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Cabinet Maker Furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) John H. Chapman Blanche Jenkins 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) Joan Courtless / Daughter 9201 Edgewood Drive Gaithersburg, Md. 20877 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta Dec. 15 1 ☐ Burial 2 【Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 2000 22. Name end Address of Fecility DeVol Funeral Home 21. Signature of Funded Service License 10 E. Deer Park Dr. Gaithersburg, Md. 20877 or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, use. List only one cause on each line. Approximete fntervel Batween Onsef end Death Immediate Ceuse (Finel · Atherosclerotic Cardiovascular Disease disease or condition rasulting in deeth) Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disaasa or Injury that initiated events resulting in death) Lest Due to (or as e consequenca of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown Carcinoma of the Eve 1 Yes 2 No 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 DINO

Physician /Medical Examiner

buriel-transit

ettending physician for use es the burie

signed by the e

Physician

/Medical

Directo

Funeral

Completed by

Be

10a Stete

Examiner

Funeral

Director

sermit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show my finant or other traumatic event, the Medical Expression of the nutriced at mine.

altimore, Maryland 21215-0020

Examiner Physician/Medical þ Be Completed

To Certification:

or Attending Physician: The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

1 ☐ Yas 20 No

25.	Was case referre	d to madical						0.0	Blace of De	eeth (Check only one)
	examiner?		Hospita	al: 1 ☐ Inpafienf 2	☐ ER/Outpetienf	3□	DOA		-	Home 5 ☐ Residence 6 ☐ Other (Specify)
	Manner of Deeth 1 D Natural 2 Accidant	5 Panding invastigation	286	o. Dete of Injury (Month, Dey Year)	28b. Time of	М	28c.	fnjury et Work?	2 No	28d. Describe how injury occurred
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		. Placa of Injury - At	home, farm, strea	t, fac	tory, o	ffica		28f. Location (Street end Number or Rural Route Numb

29a. Certifier (Check only

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end placa, end due to tha causa(s) and menner es steted.
2 Medical Examiner: On the basis of examinefion end/or investigetion, in my opinion, death occurred at tha time, data and place, and due to the cause(s) end menner steted. 29c. License number

29b. Sloneture end fittle of certified KR Lillie mo

D53244

29d. Date signed (Month, Dey, Year) December 14, 2000

30. Neme and eddress of person who complated cause of deeth (Item 23e) (Type, Print)

Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852 31. Dete filed (Month, Day, Year)

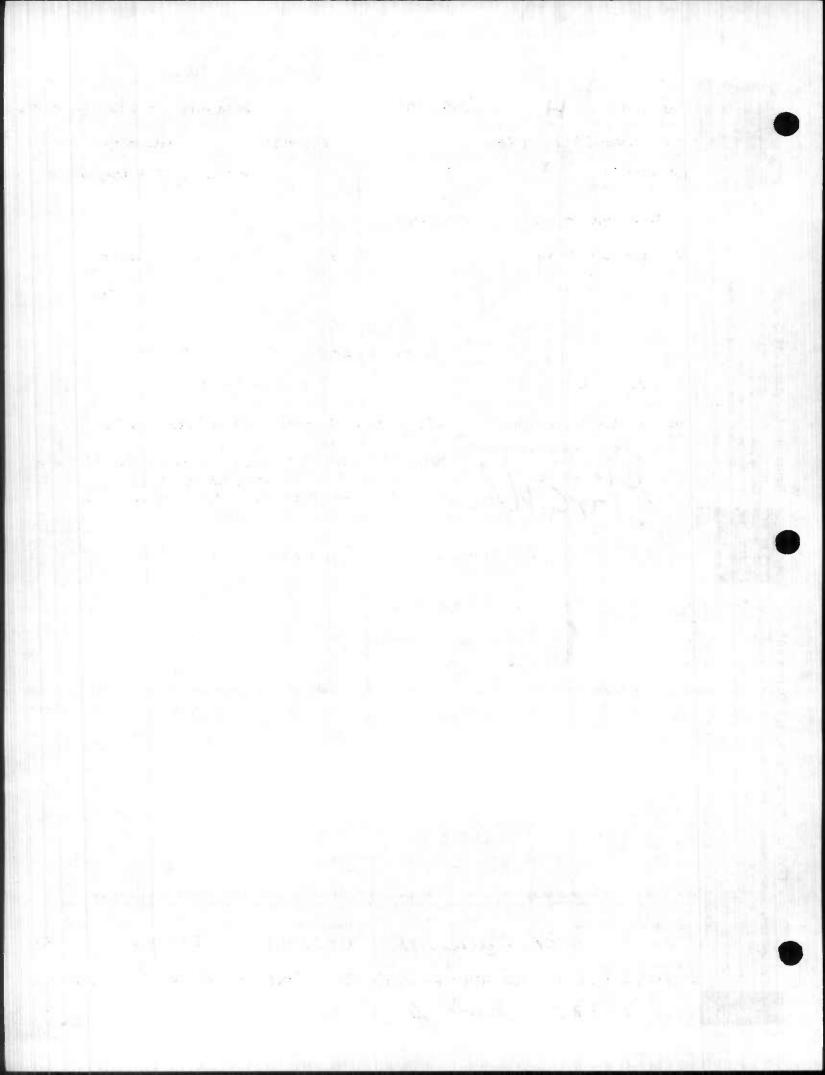
State Registrar

Medical

DEC 19 2000 32. Registrer's Signeture

To the Hospital or Attending Physi within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral dir



State of Maryland / Department of Health and Mental Hygiene

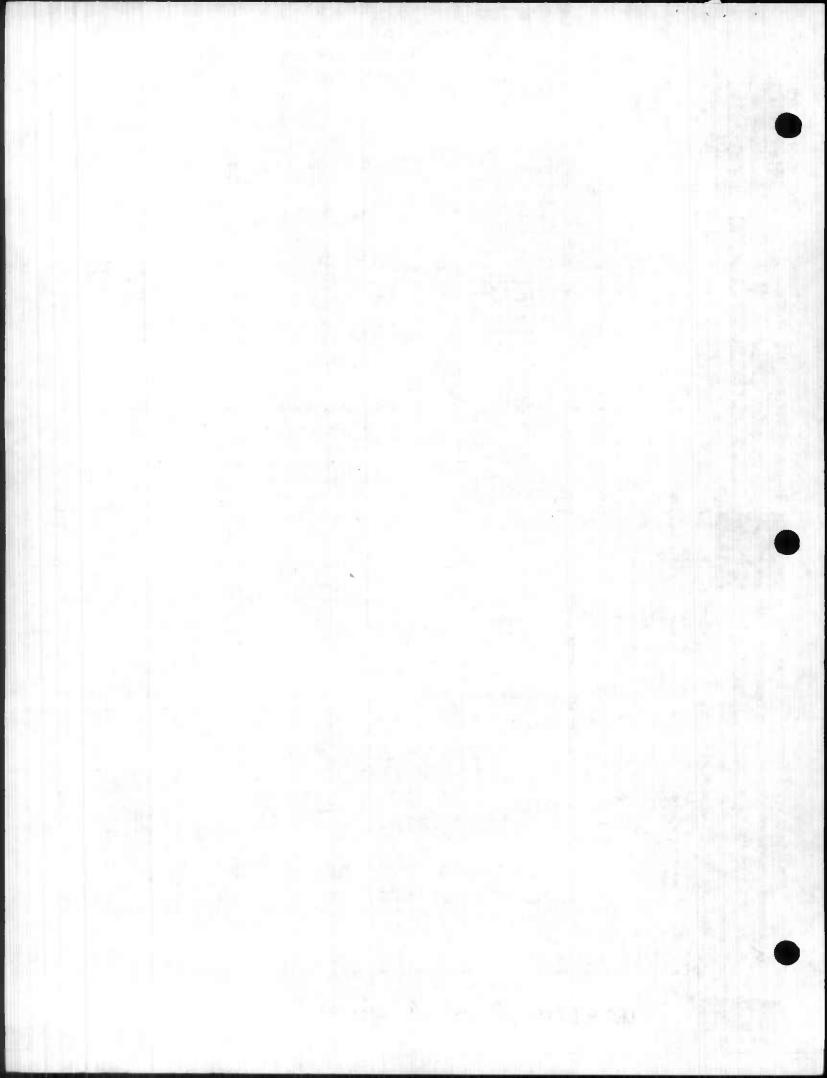
Certificate of Death

Reg. No. 42139

п	Physician	Decedent's Neme (First, Middle	e, Last)						2	Dete of Death Month	Day	Year	3. Time of Deeth
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		Washington Adve				If Under 1 '		akoma	a Par		Montgo		
П	Funeral	5. Social Security Number 214-32-9824	6. Sex 7. A	Age (In yrs. las	Yrs.			Hours	Min.	B. Dete of Birth (Month, Dey,			plece (Stete or Foreign
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	show show	10a. Stete 10b. County		10c. City,	Town or Loc	ation	-11					1	0d. Inside City Limits
	Mar miles	Maryland Montgo	omerv	Silv	er Sp	ring							1 ☐ Yes 2☐ No
	or 28s-f s	10e. Street and Number				10f. Zip Co	ode	11.		10	g. Citizen of W	het Cour	ntry?
	with w	12432 Palermo I	rive			20904			350		United		
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	s 1 end i Health tarn 27 other tu	Edith K. Dubik 20e. Method of Disposition	/ Wile	20h Plo		Paler		or. S	ilve	r Sprin	g, MD 2 0c. Location - 0		
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Registrar

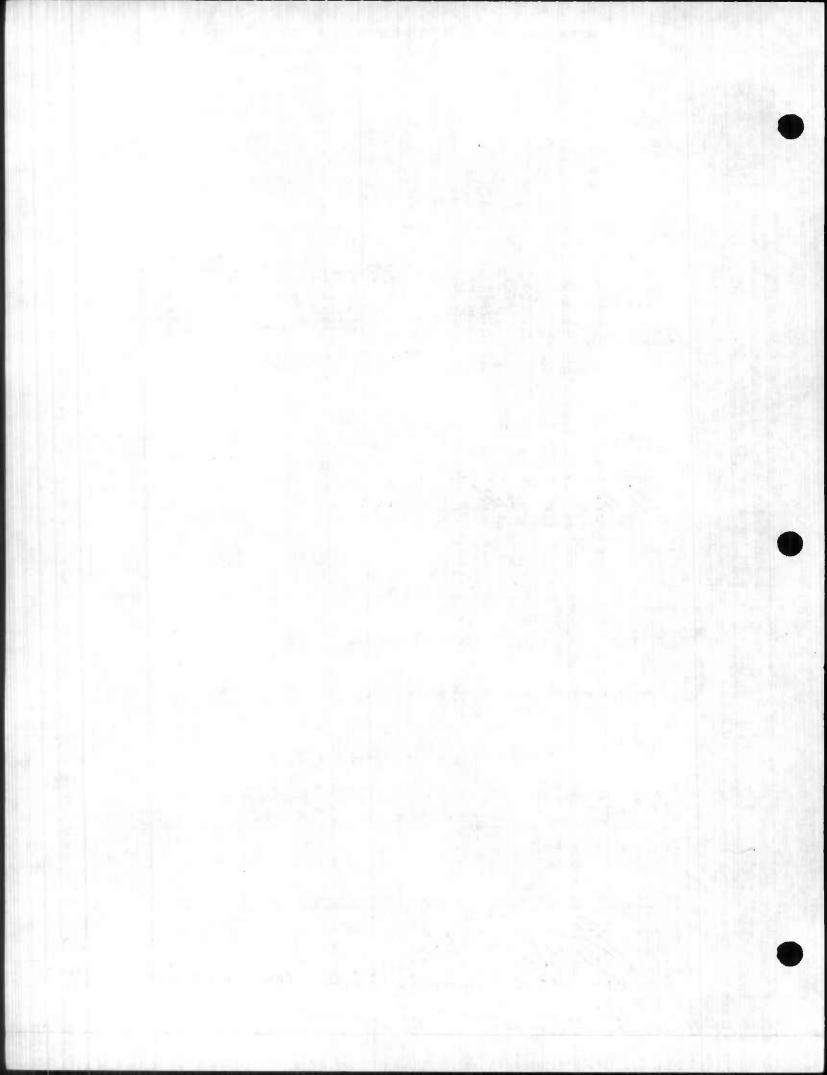


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					Certifi	cate of	Death		Reg. No.	U 4	611	rt ()
		1. Decedent'a Nama (First, Middla, L	ist)					2. Date of I		Yea		Time of Death
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Exam	ner	Holy Cross Rehab			sino (Ctr	Burto	nsville	Mc	ontgom	erv	
Funeral Director				ga (In yrs. last bii	thday) If I	Under 1 Year onths Days	If Under 2 Hours	4 Hrs. 8. Date of I	Birth Day, Year)	9. B	lirthplace Country)	(State or Foreign
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or 28	Directo	10e. Street and Number			10	0f. Zip Coda			10g. Citiz	zen of What (Country?	
23a	ai	4212 Dustin Road			2	20866			USA			
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Mental Mental arked o	To	Martin O'Connor					Ellen	Carr		H.A.		
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To the Hospital or Attending Physicien: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpati		Tima of njury	28c. Inju		sing Home 5 Re 28d. Descrit			pecify)	
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20		1/0001	Law	aby	0.15	20	083	07	1	2/10	9/2	000
		30 Name and address of person who	completed cause of a	death (Item 23a)	(Type, Print	,450	Forth	07 Jerde R	d Su	te 100	i La	1) 2072
St Regist	ate rar	31. Date filed (Month, Day, Year) DEC 2 2 2	32 Feelst	rar's Signature	9. 1	parks						

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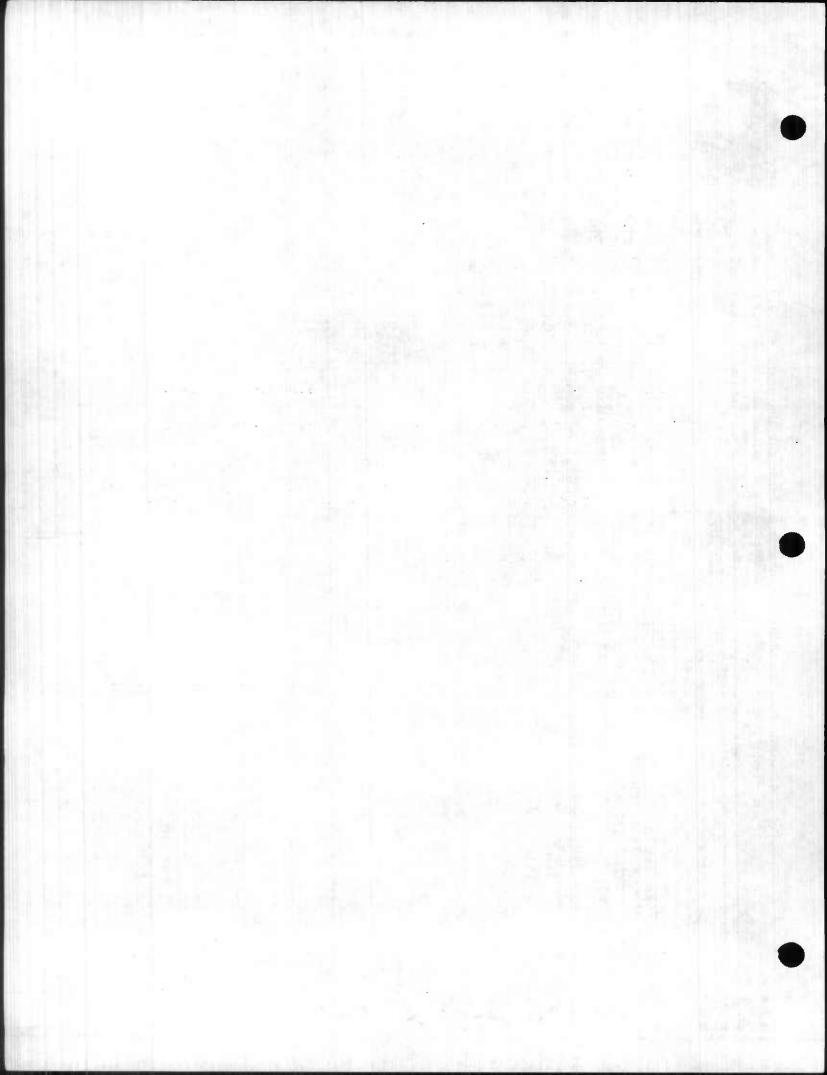
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Yee **Physician** December 18, 2000 5:19 pm Mary Ann Degnan /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 9705 Merwood Lane Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Deys Hours Months 55 Director 217-44-7026 May 7, DC Usuel Residence of Decedent the Merylend r 28a-f ahow 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? filed within 72 hours after deeth with "natural", or items 23s or 9705 Merwood Lane 20901 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Meritel Stetus Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Detes: by White 3 ☐ Widowed 4 ☐ Divorced the Medical Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiena. Teacher Aid 12 Education 7 is marked other traumatic event, it permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy, Important: if flam 27 is marked othe any Injury or other traumatic event, pages. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Stephen A. Coniglio Anna Rose DeStefano 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Philip A. Degnan / Husband 9705 Merwood Lane, Silver Spring, MD 20e. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State Dete 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/22/00 Silver Spring, MD 22. Name end Address of Fecility
Francis J. Collins Funeral Home, Inc. toer 500 University Blvd., W, Silver Spring, MD 20901 23a. PentY Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical Pancreatic Cancer Examiner Due to (or es e consequence of) Examin attending physicien and for use es the burial-transit the death certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Box 68760. Physician/Medicai Due to (or es e consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given In Pert I. 1 Yes 2 No 3 Probably 4 Unknown The law requires that Division of Vital Records. p 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? should 24e. Wes en eutopsy performed? Completed is certificete has I 1 Yes 2 No 1 ☐ Yes 2 No Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ tnpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XXNo 10 this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 1 Neturel 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending Privitin 24 hours after deeth.

To the Funeral Director: After it completely filled in by the funere Certification: 28c. tnjury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier edical 29b. Signeture end title of contiles 29c. License number 29d. Date signed (Month, Dey, Year) LD D 19757 December 20, 2000 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Michael J. Hawkins, MD 110 Irving Street, NW , Washington, DC 31. Date filed (Month, Dey, Year) 32. Pegistrer's Signeture State DEC 22 oocks Registra

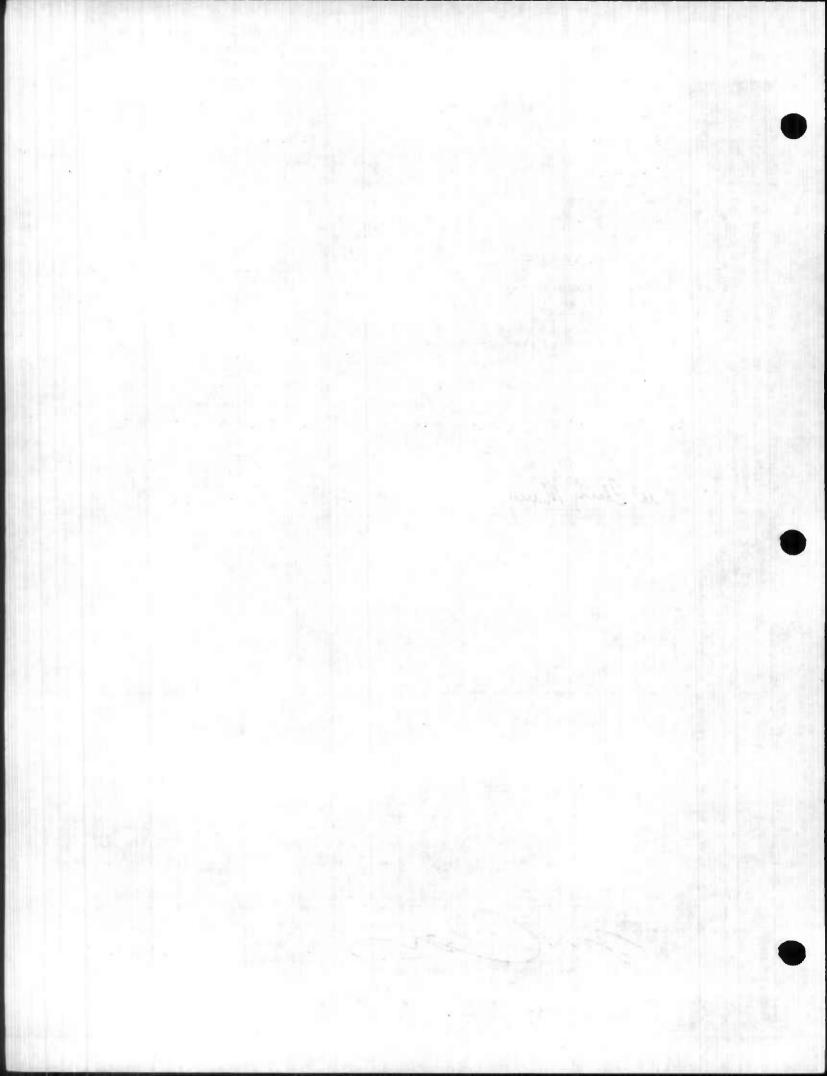


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			C	ertificate of	Death	R	eg. No.	The last of	,		
Physicia	Decedent's Nama (First, Middle,	Last)				2. Data of Dea Month	th Day	Year	3. Tima of Death		
/Medica	L'aaraa Kantami	n DeLozier,	Jr.			Decembe	r 19, 2	000	5:30am		
Examine	do Castilla blama (Mass institution	giva street and number)			4b. City, Town, or	Location of Death	4c. County	of Death			
	5944 Searl Ter	race			Bethesda		Montg				
Funeral Director	5. Social Security Number 577-03-2967	S. Sex 7. Age	(In yrs. last birtho	Months Davs		8. Data of Birth (Month, Day	, 1911	9. Birthpla Counti	ace (State or Foreign y)		
_	Usual Rasidence of Decedant		- 0,			Joury 21	, 1711		and		
ahow	10a. Stata 10b. County		10c. City, Town o		7 1			10	d. Insida City Limits		
Ba-f	MD Montgo	mery	Bethesda	1					M 182 5 140		
th 12	10e. Street and Number			10f. Zip Coda		1	0g. Citizan of W	/hat Countr	ry?		
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	George Benjami				mary I	Lucinda E	oswell				
2 sho and is m	19a. Informant's Name/Ratationsh	p (Type, Print)Daugh	ter 19b. M	failing Addrass (Stree	t and Number or Ru	ural Route Numbe	r, City or Town,	State, Zip (Code)		
rt the	Katheryn Mary De	Lozier Sloc	um 441	7 Franklin	St., Ker	sington,	MD 208	95			
of Head of Head	20a. Mathod of Disposition		20b. Place of D	isposition (Name of crematory or other pla	ace)	Data	20c. Location -	City or Tow	vn, Stata		
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permit. Pag Department important: it any injury o	W Chily	Muny		5130 Wisc	. 10	seph Gaw V. Washir			016		
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Physician /Medical	Immediata Causa (Final							1			
Examiner	disaasa or condition rasulting in death)	a. Acute S	troke					, 7	2 Hours		
			Dua to (or as a cor	nsequence of):							
P #	Hypertension										
ficate be assecuted physician and is the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying	Dua to (or as a consaquence of):									
an a mark	Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Causa (Disaase or injury										
d sic	Causa (Disaase or injury that initiated evants rasulting in death) Last	C	Dua to (or as a con	sequance of):				1			
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death certific	Part II. Other algnificant condition	d									
the de	Part II. Other significant condition	s contributing to death but	it not rasulting in th	na undarlying causa g	ivan in Part I.	23b. Did to	obacco use cor	tribute to	the cause of death		
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Attanding or death.	2 Accident Invastige	tion			Yas 2 No						
after death Director:	27. Mannar of Death 12 Natural 5 Panding 2 Accidant Invastige 3 Suicide 6 Could not detarming	ed 28a. Place of Inju	ry - At homa, farm	, street, factory, office		28f. Location (S City or Tow		er or Rural	Route Number,		
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OT NO TO	29b. Signature and title of certifier	4 1	an	29c. Licar	sa number		29d. Data signed	a (Month, E	Day, Tear)		
5	11/10	(See U	394	56	I	ecember	19,	2000		
1531	30. Nama and addrass of person w	ho complated causa of de	ath (Item 23a) (Tv	rpe, Print)							
	Lila T. McConne			Ave, #930	. Chevy (Chase. MI	20815				
	24 Date filed (Meeth Day Veer)	1	r's Signatura			,					
State	31. Data mod [Month, Day, 1941]			book							

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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year 2000 11:45 PM 17 Elder Dec. Robert Armstrong 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Chevy Chase Chevy Chase Montgomery If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 8. Dafe of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthpleca (Stete or Foreign Country) 15 M 2□ F 89 March 6 1911 Missouri 072-12-2670 Usuel Residence of Decedent 10a Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1☐Yes 2☐No Washington, DC N/A N/A 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? United States 4222 Brandywine Street 20016 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☒ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Smithsonian Elementary/Secondery (0-12) College (1-4or 5+) Museum 4 Curator 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Robert Sr. Margaret Hanna 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Pnint) 2105 Rock Quarry Road, Columbia, Missouri 65201 William H. Elder/Brother 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dec. 22 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory Inc 2000 22. Name end Address of Fecility
Rapp Funeral & Cremation Services, 933 Gist Ave. 21. Signature of Funeral Service Licensee MOUGEL Silver Spring, MD 20910 23e. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel diseese or condition resulting in death) 1 Week . Dehydration Due to (or as e consequence of): 1 Week Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): 1 Month Decubiti Due to (or es a consequence of): 1 Year Prostate Cancer 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 X Unknown Chronic Obstructive Pulmonary Disease 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Naturel

attending physician and for use as the burial-transit death certificate be executed Physician/Medical ed by the a signed by the by requires been si Completed The law page 2 certificate hes

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To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by

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Illed within 72 hours after death with the Maryfan Hygiene, ther tean *natural*, or lienns 28s or 28s+f show ent, the Medical Essimine mest ha notified at

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permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m

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Physician /Medical

Examiner

Baitimore,

Box 68760,

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Division of Vitai

5 Pending investigation

28e. Placa of Injury - At home, ferm, sfreef, fectory, office building, etc. (Specify)

1 Yes 2 No

29a. Certifier (Check only

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated.

29b. Signeture and little of cartifier

31. Date filed (Month, Dey, Year)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stele)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman R. Tuli, M.D 10810 Darnestown Road., Ste. 202-Gaithersburg, MD 20878

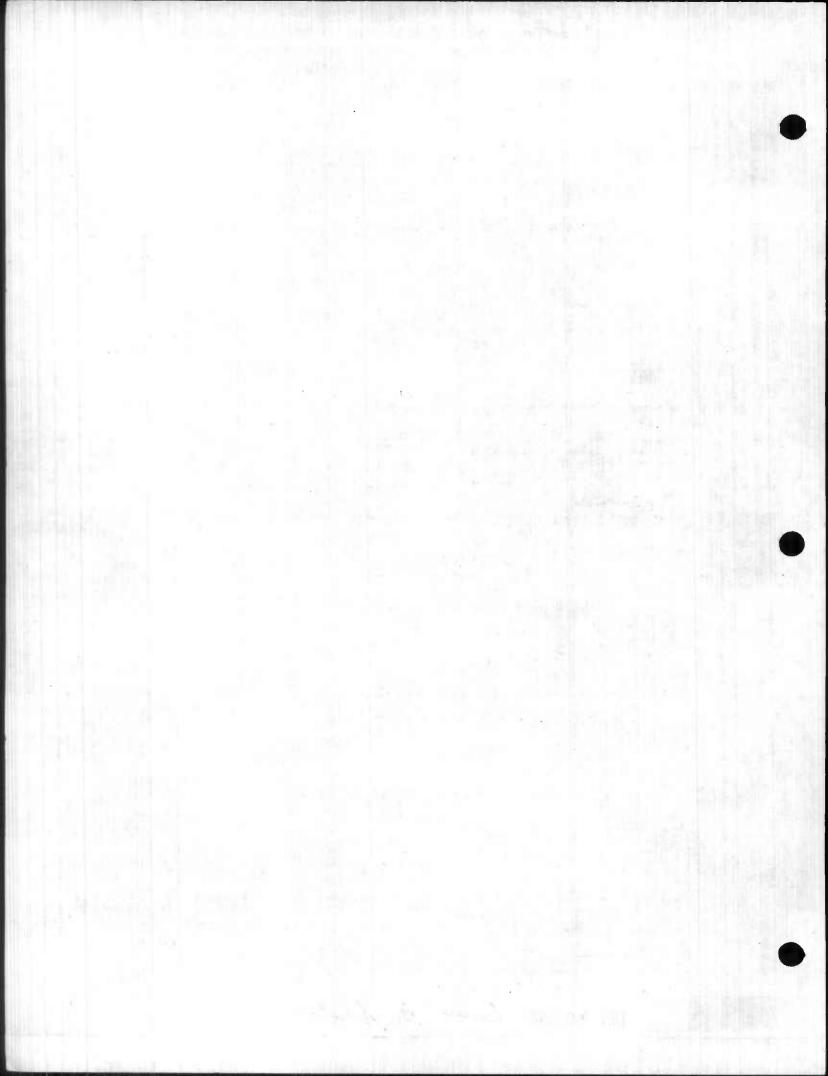
State Registrar

DEC 2 2 2000

6 Could not be determined







Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Dey William Eury 17 2000 2:00 PM Dec. 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number, 4c. County of Deeth Montgomery Montgomery General Hospital Olney If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthdey) If Under 1 Year 5. Sociel Security Number 6. Sex Birthplece (Stete or Foreign Country) 1 M 2□ F Months Deys Yrs. July 2, 1912 216-44-9564 88 Maryland Usuel Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2√ No Silver Spring Maryland | Montgomery 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code United States 20906 3475 S. Leisure World Blvd. 12. Was Decedent Ever in U,S. Armed Forces?

1 □ XYes 2 □ No If Yes, Give Year or Dates: 1942-1945 14. Reca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 [X Married 1 XYes 2 No Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondary (0-12) IIS-GPO Electrician 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Catherine Heisler Sarah Herbert Eury Charles 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 313 Westlawn Drive, Ashton, MD 20861 Donald Eury/Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition Dec. 22 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory Inc 2000 Beltsville, MD 22. Neme end Address of Fecility Rapp Funeral & Cremation Serv. Stephen D. Lohrmann 21. Signature of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that obused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. 933 Gist Ave. SIlver Spring, MD 20910 Approximete Intervel Between Onset end Death Immediete Ceuse (Finel 5 Days Acute Arterial Ischemia Right Leg disease or condition resulting in deeth) Due to (or es e consequence of): Several Year Chronic Peripheral Vascular Disease Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury . Hypertension Many Years that Initiated events resulting in death) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy

Physician /Medical Examiner

The law requires that the death certificate be executed

or Attending Physician: efter deeth.

To the within 2

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this

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23s or 28s-f show Exeminer must be notified at

1 and 2 should be filed within 72 hours efter Health and Mental Hygiene.
am 27 is marked other than "natural", or its the traumatic event, the Medical Examina

permit. Pages 1 and 2:
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Examiner and Il-transit physician ar s the bunal-tr Physician/Medicai SE for use as signed by the a þ should should Completed pega 2 s i director, p Be Certification: To After this n 24 hours efter deeth. The Funeral Director: A pletely filled in by the fu

Pert II. Other significant conditions contributing to death but not resulting In the underlying cause given in Pert I. Coronery Artery Disease

Renal Insuffiency Stroke 26. Piece of Death (Check only one)

25. Wes case referred to medical examiner? Hospital: 1 ☑ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Deeth 28b. Time of

1 XNaturel 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Dey Year)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and pleca, end due to the ceuse(s) and manner stated.

1 Tes 2 No

28d. Describe how injury occurred

29b. Signature end title of certifier

29a. Certifier

(Check only

one)

edicai

29c. License number

29d. Date signed (Month, Dey, Year)

1 ☐ Yes 2 ☐ No

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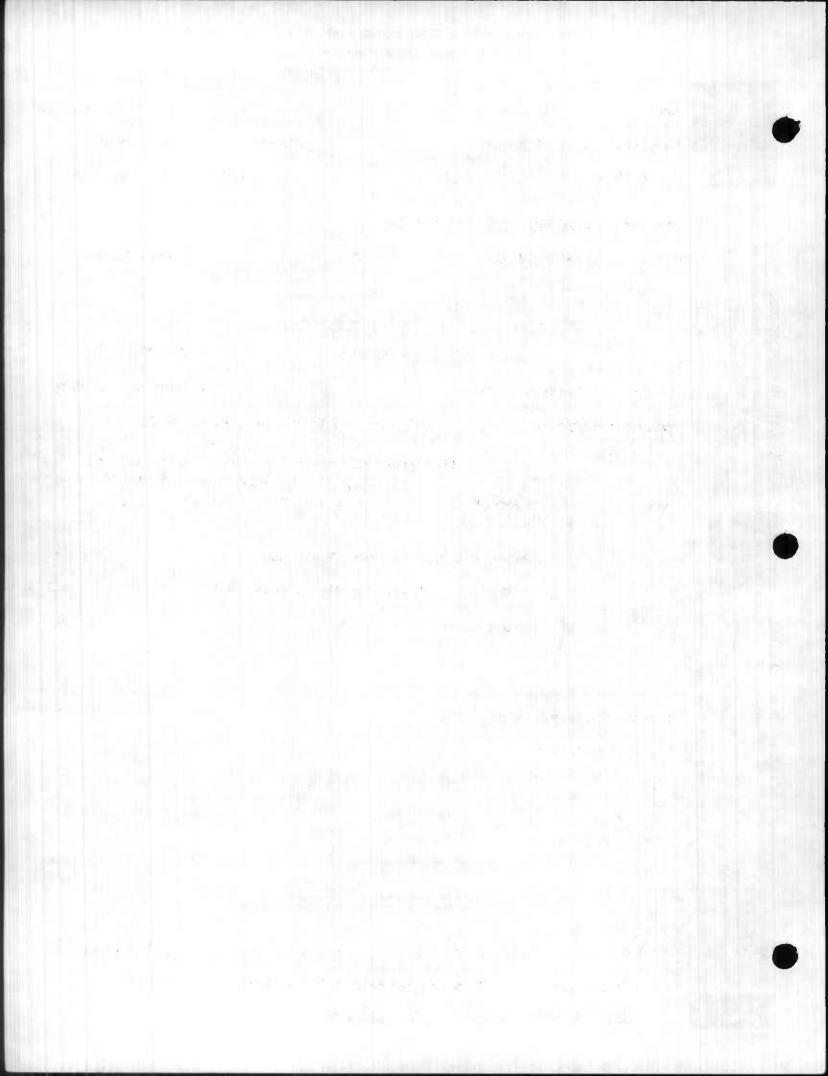
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

9715 Medical Center Drive, Rockville, MD 20850 Pamela A. Wright, M.D.,

State Registrar 31. Date filed (Month, Dey, Year) DEC 2 2 2000





State of Maryland / Department of Health and Mental Hygiene

			Cei	tificate of	Death		Reg. No.	46140	
	1. Decedent's Name (First, Middle, Li					2. Dete of De	eeth Dey	3. Time of Death	
hysician /Medical	FRANCES J.	EVANS				A EC	ember 1	4,2000 11 BM	
	4e Facility Neme (If not institution, gi				SALISB	or Location of Deal			
	WATERVIEW H			if Under 1 Yeer					
erai		Sex 7. Age (In yrs. 1 ☐ M 2 1 F 83	last birthdey) Yrs.	Months Deys	If Under 24 H Hours M	lin. (Month, D	Date of Birth (Month, Dey, Year) 9. Birthplece (State or I Country)		
	216-14-2581 Usuet Residence of Decedent	03	110.			March	4,1917	Maryland	
-	10a. Stete 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits	
by Funeral Director	aryland Somers	et	W	estover				1 ☐ Yes 2 No	
Director	10e. Street and Number	632.0		10f, Zip Code			10g. Citizen of V	Vhat Country?	
	6898 Boggs Schoo	lhouse Road		218	371		USA		
Funeral	11. Merital Stetus	12. Wes Decedent Ever in L		Was Decedent of H	lispanic Origin?	(Specify Yes or N		a - American Indien,	
2	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		f Yes, specify Cub		ierto Hican, etc.)		k, White, etc.	
by	3 XWidowed 4 □ Divorced	If Yes, Give Yeer or Dates:		I ☐ Yes 2 No	Specify:		Specify	White	
Completed	15. Decedent's E		16a. Deced	lent's Usuel Occup	etion	wateine	16b. Kind of Bu	siness/Industry	
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Be	17. Father's Neme (First, Middle, Las.			The Line		Neme (First, Middle		e)	
5	Sydney James	Justice			Elsi	ie Lawson	1		
	19e. Informant's Neme/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	end Number or	Rural Route Numb	per, City or Town,	Stete, Zip Code)	
	James W. Dize, Jr.	(nephew)	6898	Boggs Sch	noolhous	se Road -	Westove	r, MD 21871	
	20e. Method of Disposition			sition (Name of netory or other ple	ce)	Dete	20c. Location -	City or Town, State	
	1 Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	JHemovel from State				12/18/00	Crisfi	eld, MD	
	21. Signature of Funerel Service Lice			Name and Addre	ss of Fecility				
	* Kampl-	Bund leven				Funeral - Crisf		21817	
+	23e. Pert 1. Enter the disease, or con		th. Do not ent					Approximete	
W.	shock, or heart feilure. List only	one cause on each line.						Interval Between Onset end Death	
	Immediete Cause (Final	PANEZA						icut.	
	disease or condition resulting in death)	PNEUL						iwk	
Je l		Due to (or es e conseq	juenca or):				1	
Examine	Convention by list conditions	b. — Due to (or es e conseq	menca ot).					
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	200.00							
edical	Cause (Disease or injury thet Initieted events	C Due to (or es e conseq	uenca of):					
Med	resulting in death) Last								
		d						1	
SICE	Pert II. Other significant conditions	contributing to death but not re-	sulting in the u	nderlying cause giv	ren in Part I.	23b. Dio	tobacco use co	ntributa to the causa of death?	
Physician	DEMU	La				10	Yes 2 No	3 □ Probably 4 ☑ Unknown	
by									
Completed	DEA.	TUBE					s en eutopsy ormed?	24b. Were eutopsy findings evellable prior to	
bie	LE OL	101.70				-		completion of cause of death?	
E						10	Yes 2000	1 ☐ Yes 2 ☐ No	
0	25. Wes case referred to medical				26. Plece of I	Deeth (Check only			
0	examiner?	Hospitel: 1 Inpatient 2	ER/Outpetier	t 3 DOA Oth	or:	g Home 5 ☐ Res		er (Specify)	
	27. Menner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of		y et	28d. Describe	how injury occur	red	
atio	1 Netural 5 Pending investigation		Injury		Yes 2 □ No				
2	3 ☐ Suicide 6 ☐ Could not to determined	28e. Pleca of Injury - At h building, etc. (Speci	ome, ferm, str	eet, fectory, office			(Street end Numb	per or Rurel Route Number,	
Certification:		Juliding, etc. (Speci	7)			Oily or 10	, 5.0.0/		
		nysician: To the best of my knowning: On the basis of examine							
	one)	and menner steted.							
Σ	29b. Signeture end title of certified	.10		29c. Licens	se number		29d. Date signe	d (Month, Dey, Year)	
	blumb W	W9_		7	32014		12/15	700	
	30. Neme end eddress of person who	completed cause of death (Ite	m 23a) (Type,	Print)		-		in Tloral	
	MAHESY MOU	NOTA -106 W	MILTERA	7545	04 B	sallissi	ind a	100 100 10 4804	
ate	31. Dete filed (Month, Dey, Year)	32. Registrer's Sign	ature	-					
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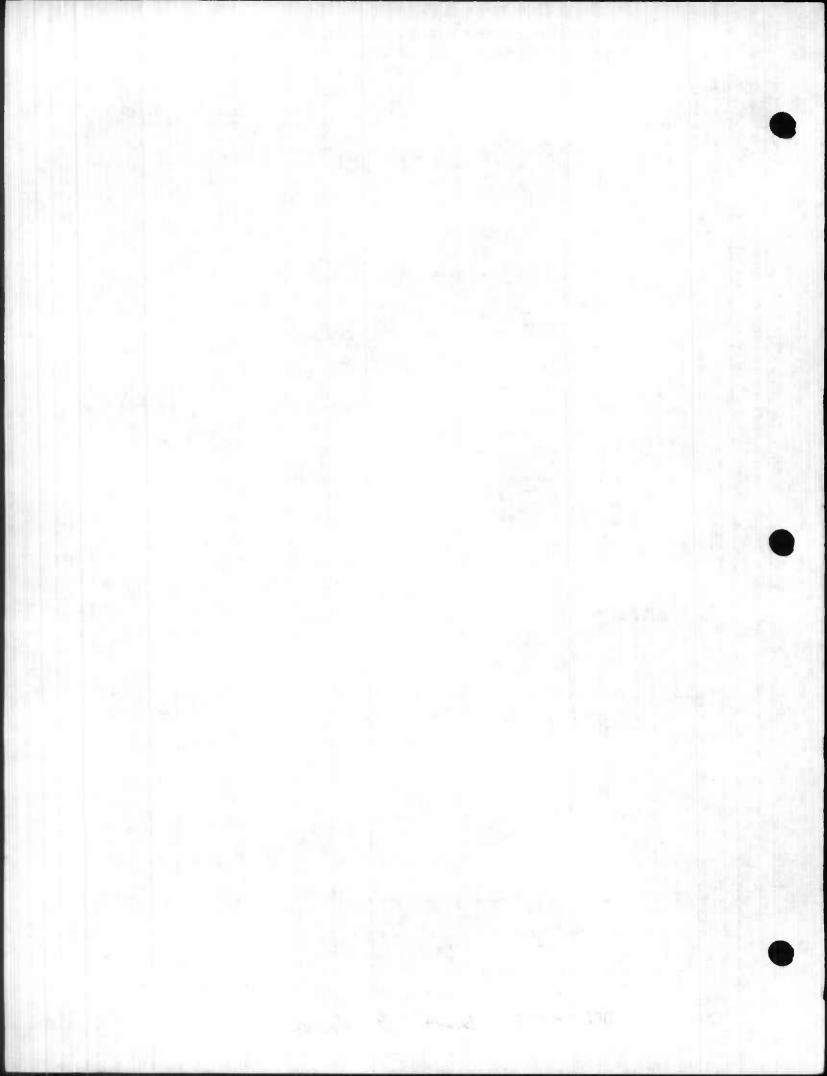
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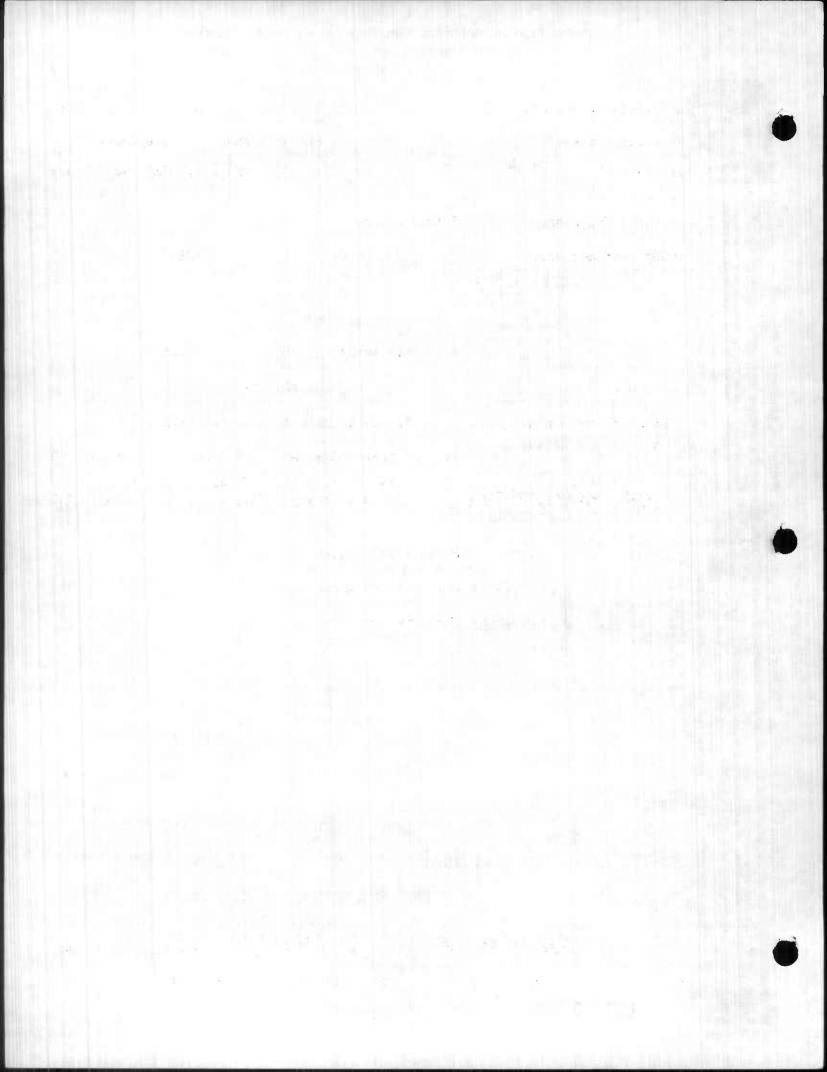
Certificate of Death

				Cert	illicate of	Dealli		Reg. No.		
п		1. Decedent's Neme (First, Middle, Las	st)				2. Dete of De		Year	3. Time of Deeth
	Physician	CHARLES WILLIAM	M ELZA				Month	er 20.	2000	3:20 P.M
	/Medical	4e Facility Neme (If not institution, give				4b. City. Town, or L				J.20 1.11
50	Examiner							,		
	²	SACRED HEART HOST			If Under 1 Year	CUMBERLAN		ALLEC		
п	Funeral	Months Days Hours Min. (Months.							9. Birthp	lace (Stete or Foreign try)
н	Director	235-34-2940	74	Yrs.			NOVEMBE	R 1 1926		
	D	Usual Residence of Decedent								
	wor	10a. Stete 10b. County	10c. Cit	y, Town or Loc	ation				10	0d. Inside City Limits
	Mar 1 st	W.VA. MINERAL		TROPIES	7					1 ☐ Yes 2 ☐ No
	vith the Mar or 28s-f s be notified Director	W.VA. MINERAL		IDGELEY	10f. Zip Code			10a. Citizen of V	Vhet Coun	itry?
										.,,
	123 123	RFD#2 BOX#579			26753			U.S.A.		
	72 hours effer deeth with the Maryland natural", or frame 23a or 28a 4 show like Earning must be notified a sted by Funeral Director	11. Meritel Stetus	12. Wes Decedent Ever In U Armed Forces?	,S. 13. W	es Decedent of H Yes, specify Cube	lispenic Origin? (Spen, Mexicen, Puerto	pecify Yes or No Rican, etc.)	Blec	e - Americ k, White,	
0	of a man		NOYes 2 No fryes, Give		□ Yes 2☐No	Specify:		Specify		
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21215-0020	d 2 should be filed within 72 hours th end Mental Hygiene. 7 is marked other than "natural", fraumatic event, the Multal Em TO Be Completed by	15. Decedent's Ed	etion		16b. Kind of Bu	siness/Inc	dustry			
11.5	ole and	(Specify only highest gra	College (1-4or 5+)	life. D	and of work done of NOT use retired	during most of wor	king			
12	with sene.	Elementery/Secondery (0-12)		73.73 4.77.734						
	should be filed within of Mentel Hyglene. marked other than " imatic event, tre Me			MESIEF	RN MD. RA	18. Mother's Nan	e (First Middle	BRAKEM Maiden Sumem	Andreador V	
Ĕ	d out					TO. MOUTOI S MAIN	ie (r ir st, ibiroore,	Maroon Somon	0,	
yie	should be and Mentel or marked o umatic eve	RESSIE WILLIAM EI	LZA			DAISY M	AE ARBO	GAST		
Maryiand	end end is m	19e. Informant's Neme/Reletionship (Type, Print)	19b. Mailing	Address (Street	end Number or Ru	ral Route Numbe	er, City or Town,	State, Zip	Code)
Σ	end 2 selth e n 27 is	JEAN ELZA	WIFE	RFD#2	BOX#579	RIDGELEY	. W.VA.	26753		
e,	-755	20a. Method of Disposition	20b. F	Plece of Dispos	ition (Neme of		Dete	20c. Location -	City or To	wn, State
ō	M H M	1 ☐ Burial 2 ☐ Cremetion 3 ☐	Removal from Stete	cemetery, crem	etory or other pled	ce)				
E		4 ☐ Donation 5 ☐ Other (Specify	y) SUN	SET CEM	ETERY DE	ECEMBER 2	3 2000	CUMBERLA	ND M	ARYLAND
Baltimore,	Depertmen Important: any Injury ange.	21 Signature of Funerel Service Licen	194		Name end Addre					
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н		23e Pert Enter the disease or com	plinations that caused the deal			STREET			LAND	Approximete
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	Physician		AA 1 ()1						1
-11	/Medical Examiner	Immediate Ceuse (Final disease or condition	· Myelot	bros	3/5					4 mo
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	certificate be executed triing physician end isse as the bunal-transit		b. Due to (c	or es e consequ	ionon off:					
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20	The law requires rate has been sign pege 2 should be							en eutopsy rmed?	ev	ere eutopsy findings ailable prior to
S	law respectively								of	mpletion of ceuse death?
ä	The law page 2						10	Yes 2 No	1.0	Yes 2 No
a	E specification								1.0	1165 212(10
of Vital Record	Physicien: The lithis certificate he ral director, pege	25. Wes cese referred to medicel examiner?	Use-itali		100	26. Plece of Dec	oth (Check only	one)		
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	g PI	27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. tnju	ry et	28d. Describe	how Injury occur	red	
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S	dee ctor y the y the	3 Suicide 6 □ Could not be	28e. Piece of Injury - At h	ome, ferm, stre	et, fectory, office		28f. Location (Street end Numb	er or Rure	el Route Number,
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	Ne Hosp no 24 hours Ne Funer pletely fil		ysician: To the best of my knowledge: On the basis of examine							
	Po Figure H	one)	end menner stated.	MION BRIDGE HIV	estigetion, in my c	pinion, death occu	med et tile tilile,	data and piece,	BIIG GUO IC	o the cease(s)
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	6.5, 6.	Taw J. O	wer good	mu		23774		Decembe	ra	/ 2000
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				C	ertifica	ate of	Death		Reg. N	0 0	42	114	7
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Cross Hos Security Number	6. Sex	7. Aq	a (In yrs.	last birthda			Silver S	8. Date of E	irth	- 4	omery 9. Birthol	ece (State	a or Foreigi
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et and Number					-	Zip Code			10g. C	itizen of V	Whet Count	ry?	1000
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(Specify only high: ntary/Secondary (0-12)	-	Collega (1-4or 5	i+)	life	DO NOT	use retin	during most of wo	orking					
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ar's Nema (First, Middla	a, Last)						18. Mother's Na	ma (First, Midd	ia, Maida	n Sumam	na)		
ius Solana	S						Maria P	ratts					
ormant's Name/Ralation	nship (Type,	, Print)		19b. M	ailing Addra	ass (Stree	at and Number or F	lural Routa Num	ber, City	or Town,	Steta, Zip	Coda)	
rah F. Bow	les/	Daughter		1050	08 Te	nbro	ok Drive,	Silver	Spr	ing.	MD 2	0901	
hod of Disposition			20b F	Place of Di	sposition (foramatory o	Vama of		Data			City or Tox		
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ta Causa (Final or condition in death) ially list conditions, ading to immadiata enter Undarlying liseasa or rinjury ated avants in death) Last	6. I	Pulmonar	Due to (conterns) Due to (contents) Due to (contents) Due to (contents)	titia orasacon perte	sequanca o 11 Pne sequenca o ensior sequance o	of): eumon of): 1 f):	itis	23b. Di	d tobacc	co use con	ntribute to	the caus	ne of death
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ner of Death Naturel 5 Pand Accidant invas	ling tigation	28a. Data of Inju (Month, Day	Year)	28b. Tima Injur		28c. Inje W	ury et ork? □Yes 2□No	28d. Describ	e how in	jury occuri	red		
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tifiar 1 Certifyi	ing Physici Il Examiner	an: To the best of : On the basis of and mannar sta	axamine	wiedge, de tion and/o	ath occurre investigati	ed at that on, in my	tima, data and place opinion, death occ	a, and dua to the curred at tha tim	e ceuse a, data a	(s) end me nd placa,	ennar as stand dua to	ated. tha causi	B(S)
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July /	Tai	elle,	21	10	>	D	1881	2	Dec	ember	r 18,	2000)
and addrass of person													
Tauber, MD					#304,	Sil	ver Spri	ng, MD	2090	2			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Deeth 2. Date of Death 1. Decedent's Name (First, Middla, Last) Day Yaar **Physician** 1039 JACQUELING FERRESL Downer 2000 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner SICURA SPRING Moutborony 1901 EAST-WEST HIGHWAY If Undar 1 Yaar | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) **Funeral** 1□ M 2\ F Days Hours Yrs. 75 Director Dec 16, 1924 | Haiti 132-34-5830 Usual Rasidanca of Dacedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show 1 ☐ Yas 2 🗖 No Directo Maryland | Montgomery Silver Spring 10f. Zip Coda 10g. Citizan of What Country? 10e. Street end Number r than "naturel", or items 23s or the Medical Examiner must be r 1901 East-West Highway 20901 Funeral USA death 12. Wes Dacedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - American Indien. Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) Black, White, etc. at 1 and 2 should be filed within 72 hours after of Health and Mentel Hygiena. I lear 27 is marked other than "naturel; or the other traumatic event. The 1 □ Naver Marriad 2 □ Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowad 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Spacify only highast grada completed) (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 Secretary World Bank 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fether's Nama (First, Middla, Last) Be Antoine Ferrer Alice Artaud 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) Max Etheart/ Son 10608 Margate Road, Silver Spring, MD 20901 Baltimore, 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 20a, Mathod of Disposition Data Pages nant of h 1 Burial 2 Cramation 3 Ramoval from Stata Metropolitan Crematory 12/16/00 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Addrass of Facilit 21. Signature of Funeral Sarvice Licensae Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, or heart failure. List only one cause on each line. Approximata Intarval Between Onset end Death Physician ANTERIOSCIEPOTIC OPPOINTSLUBBLE DISEBYE /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequanca of): DIABOTOS MECLITUS Examin physician end the burial-transit tha daath certificata be axecuted Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Ceusa (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consaguance of) Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): SBS usa Po signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy Completed page 2 1 Yas 2 No 1 Yas 2 No certificate Division of Vital director 25. Was casa rafarrad to medical examinar? Be 26. Pleca of Daeth (Check only ona) 1 Yas 2 No Other: 4 ☐ Nursing Home 5 🗷 Rasidance 6 ☐ Other (Specify) P 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 28d. Describe how injury occurred 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Invastigation Natural after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) p 24 hours after Funeral Direction 4 Thomicide ŏ Hospital 29a. Carille (Chick 1 Certifying Physician: To tha best of my knowladge, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner es steted. Medical To the Hosp within 24 ho To the Fune completely fi Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and dua to the causa(s) and manner stated. 29b. Sign and title of certifier 29c. Licansa numbar 29d. Data signad (Month, Day, Year)

State Registrar 31. Data filed (Month, Day, Yaar)
DEC 1 8

32. Registrar's Signatura

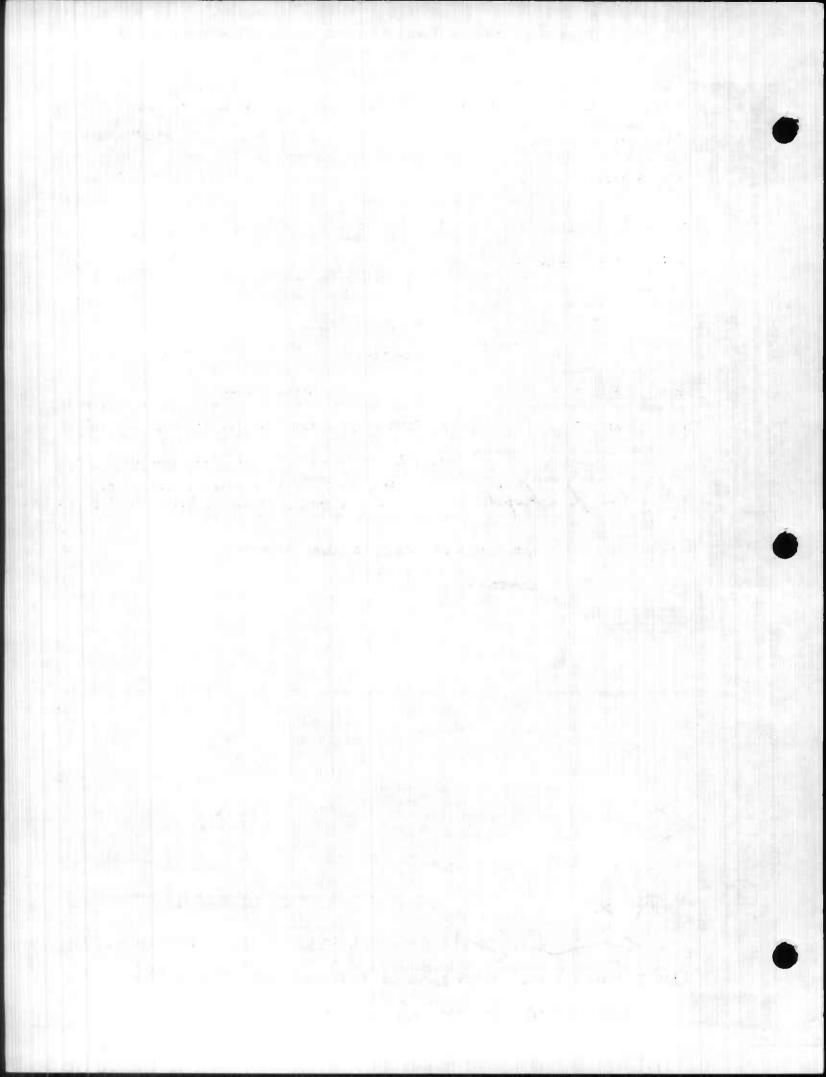
DWE

B. Sporks

30. Nama and addrass of person who completed cause of daath (Itam 23a) (Type, Print) PIKT, BOCKUIUS, MO 20852

015236

DECOMBOL 12, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Day Month **Physician** 9:30am December 13, 2000 FELDT JOHNNIE MARIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nema (tf not institution, giva street and number) Examiner Bethesda Montgomery Manor Care Health Care Center If Under 1 Yaar | If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Deys Months Hours 1 ☐ M 2 🖾 F Yrs. 89 Sept. 18, 1911 Texas Director 447-03-9212 Usual Rasidance of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiens other than "natural", or items 23s or 28s-f show ont, the Medical Examinar must be notified at 1 ☐ Yas 2 ☑ No Director MD Montgomery Bethesda 10g. Citizan of What Country? 10e. Street and Number 10f. Zin Code 20816 U.S.A. 6105 Winnebago Road Funeral 14. Race - Amaricen Indien, Black, Whita, atc. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Ricen, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 📉 No If Yas, Giva 1 Never Merried 2 Married 1 Yas 2 No Specify: Specify: py White 3 Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within Elementary/Secondary (0-12) Cottega (1-4or 5+) Own Home Homemaker 18. Mother's Nama (First, Middla, Maidan Sumama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is meried ofth eny Injury or other traumatic event gross. 17. Father's Neme (First, Middle, Last) Be Minnie Mae Reed William Oliver McGuire 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Bethesda, MD 20816 6105 Winnebago Road (Son) Alfred Walter Feldt Baltimore, 20b. Place of Disposition (Name of cematery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata National Crematory 12/19 Falls Church, VA 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility
JOSEPH GAWLER'S SONS, INC. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave., NW Washington, DC 20016 23a. Part1. Entar tha disaas or complications the focused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. Let only one cause of each tine. Approximata Interval Between Onsat and Death **Physician** Immediata Cause (Final disaasa or condition resulting in death) /Medical Cardiac Arrythmia Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be axecuted attanding physician and for use as the bunal-transit Sequantially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Causa (Disaase or injury Dua to (or as a consequence of): Box 68760 Physician/Medical thet initieted evants rasulting in daath) Last Dua to (or as e consaguance of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the undarlying ceusa given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Dementia Records, þ 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24a. Was an autopsy performed? been si Completed has b iis certificate ha 1 ☐ Yas 2 No Division of Vital Physician: Be 25. Was cesa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Lo After this 28a. Data of Injury (Month, Day Year) funeral 28c. tnjury at Work? 28d. Dascribe how injury occurred To the Hospital or Attending PP within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifiar edicai (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura end title of certifiar 29c. Licansa number December 14, 2000 (8) D35791 emmy berlyn 30. Nama and addrass of person who complated ceusa of death (Item 23a) (Type, Print)

Registrar

Merlyn K.

31. Deta filed (Month, Day, Year) Proces DEC 19 2000

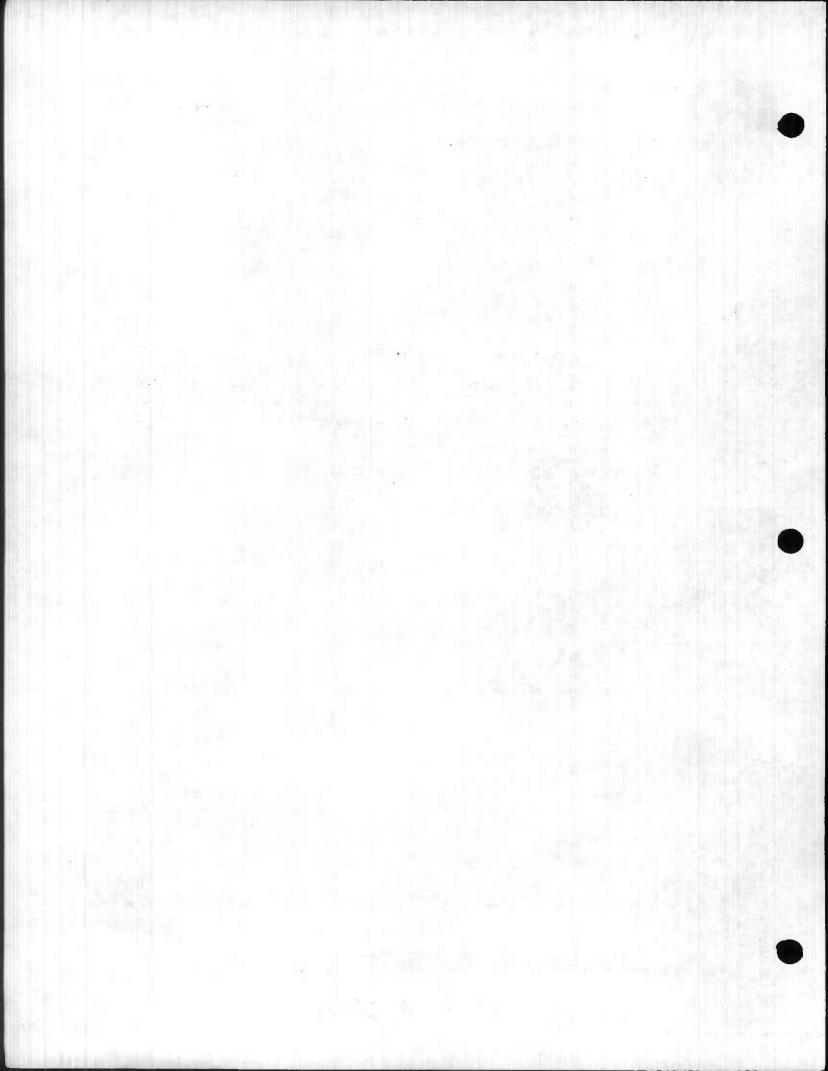
Vemury,

Georgia Ave. #227 M.D. 32. Registrar's Signatura

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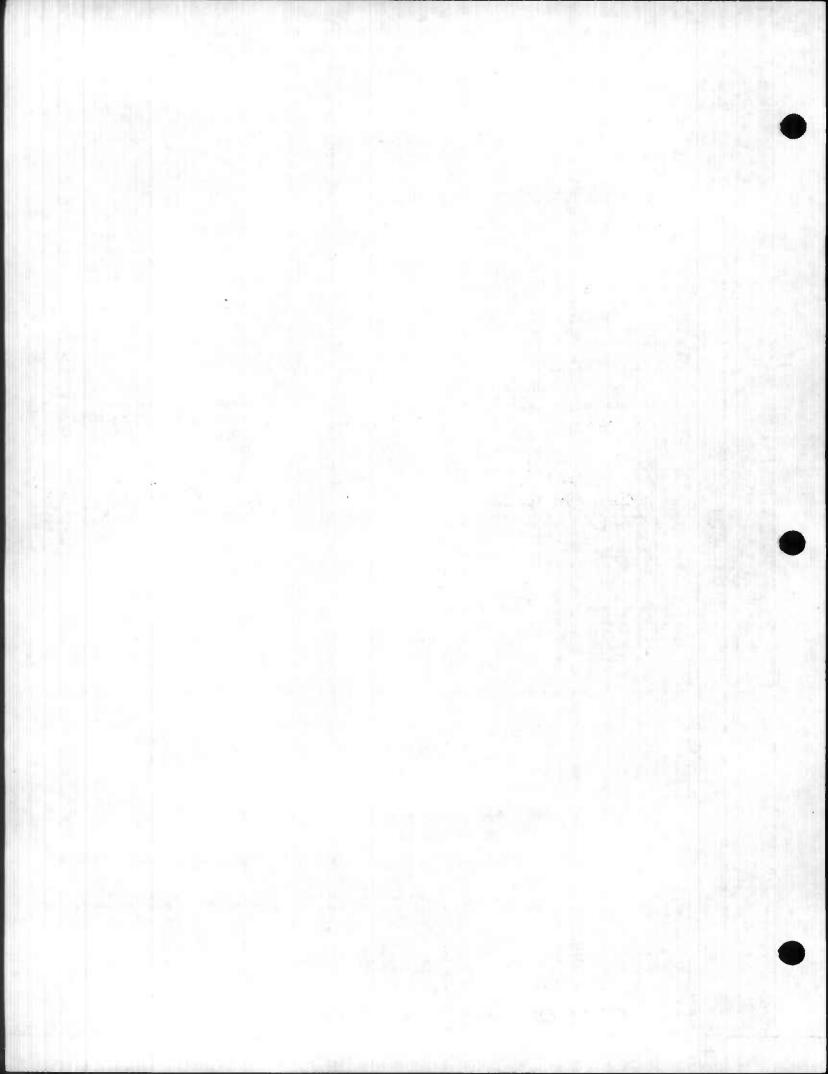
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Silver Spring, MD 20902



State of Maryland / Department of Health and Mental Hygiene 0 42 50

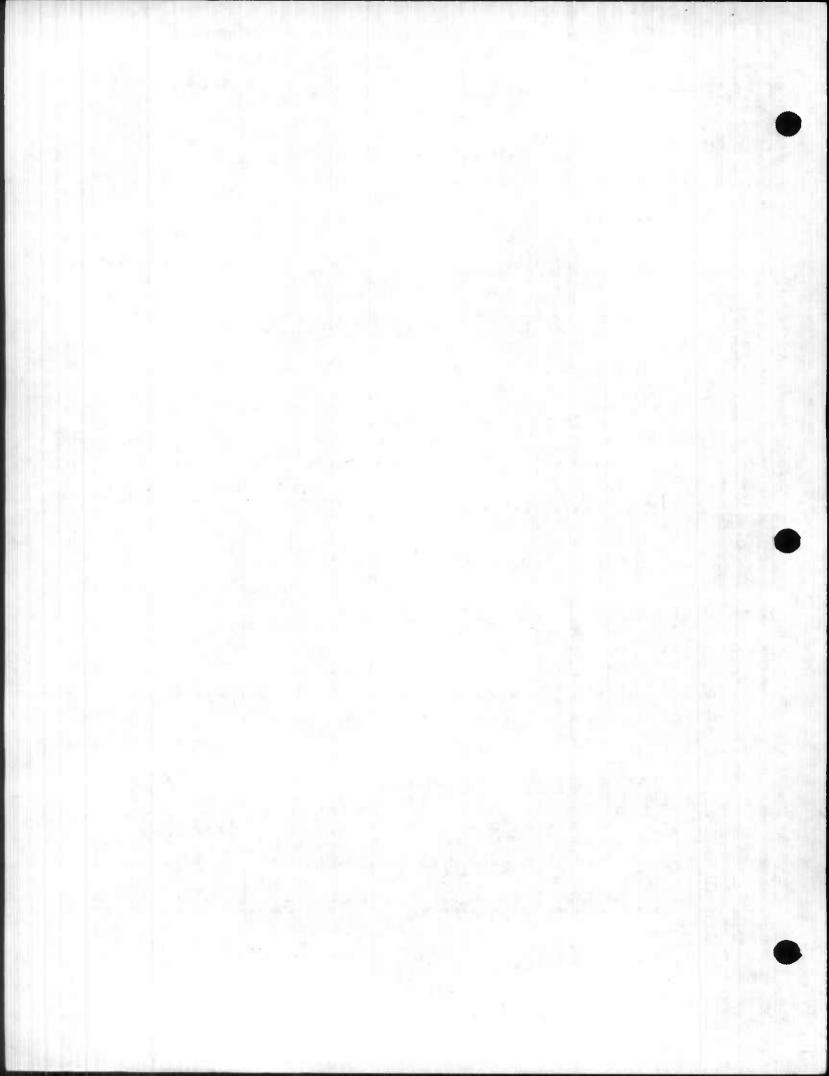
			Cen	tificate of	Death		Reg. No.	T loss	
ician	1. Decedent's Neme (First, Middle, La	st)				2. Date of De	path Day	Year	3. Time of Death
n II	Gladys Afa	nador de Gu	ızman			DECEN		2000	1056
er	4e Facility Neme (If not institution, giv SHADY GROV)	e street end number) E ADVENTIST	HOSPI		4b. City, Town, or ROCKV	ILLE		of Death TGOM	ERY
al or	5. Social Security Number 6. S 219-45-9777 Usuel Residence of Decedent	To M 2 T F S 2 T S	lest birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug 10	y, Year)		lece (State or Foreign try) ombia
	10a. Stete 10b. County	10c. City	y, Town or Loc	ation				10	Od. Inside City Limits
to	Maryland Montgome	rv	aither	shurg					1 ☐ Yes 2 ☐ No
Director	10e. Streef and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10f. Zip Code			10g. Citizen of \	What Count	try?
	9152 Turtle Dove	Lane		2087	79		Colom	bia	
Funeral	11. Maritel Status	12. Wes Decedent Ever In U, Armed Forces?	S. 13. W	/as Decedent of I Yes, specify Cub	Hispenic Origin? (S ean, Mexican, Puerl	pecify Yes or No o Rican, etc.)		e - America ck, White, e	
by	1 ☐ Never Merried 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Yeer or Detes:	1	∑ Yes 2□ No	Specify: Co1	ombian	Specify	His	spanic
Be Completed	15. Decedent's En		16a. Decede	ent's Usuel Occup	petion during most of world)	king	16b. Kind of B	usiness/Ind	dustry
mple	Elementery/Secondary (0-12)	College (1-4or 5+)						-	County Dept
S	17. Father's Neme (First, Middle, Last,	4	Socia	1 Service	e Worker		of Soci		rvices
Be		fanador				ensia		cerra	
To	19e. Informent's Neme/Relationship (19b Mailing	n Address (Street	t end Number or Ru				
		nusband			ove Lane				
	20e. Method of Disposition	20b. P	lace of Dispos	sition (Neme of satory or other ple	1	Dete	20c. Location		
	1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Gat	e of H	eaven Ce	emetery	Dec 27, 2000	Silver	Sprin	ng, MD
	21. Signature of Funeral Service Lon	L -		Name end Addre			Funeral		20077
	23s Parti Fester the figures or conf	plications that caused the death			r Park Dr			, MD	20877 Approximete
	23s. Part 1 Enter the dispese, or com- shock or heart failure. List only	one cause on each line.	i. Do not sine	ii ula liloda di dyi	ing, such as curdial	or respiratory o			Intervel Between Onset end Death
1	Immediate Ceuse (Finel	BRACI	U DE	ATH					11114
	disease or condition resulting in death)	8.	r es a consequ					1	COAT
ě					HEM OD	RHAGE	_		60HYJ
Exami	Sequentially list conditions, if any, leeding to Immediate cause. Enter Undertying Cause (Disease or injury	0.	r es e consequ		770700	, , , , , ,			
Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last		r es e consequ	ience of):	Ħ.				
Physician/	Part II. Other significant conditions of	ontributing to death but not rest	ulting in the un	derlying cause gi	iven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?
						10	Yes 2 No	3 Prot	bably 4 Unknown
Completed by						24a. Wes	s en eutopsy ormed?	COL	ere eutopsy findings eilable prior fo mpletion of cause deeth?
E						10	Yes 2 No	10	Yes 20KNo
BeC	25. Wes case referred to medical				26. Plece of De	eth (Check only	- /-		
	examiner?	Hospitel: 1 Inpatient 2	ER/Outpatient	3□ DOA Ot	hor:		idence 6 Ott	ner (Specifi	y)
tion: 1	27. Manner of Death 1 Neturel 5 Pending 2 Accident investigatio	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	iry et ork?] Yes 2 ☐ No	28d. Describe	how injury occur	red	
ertifica	3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specify	ome, ferm, stre	et, fectory, office		28f. Location City or To	(Street and Numi wn, State)	ber or Rura	al Route Number,
edical Certification: To	29e. Certifier (Check only 2 Medical Exam	yaician: To the best of my knowniner: On the basis of examined and menner steted.	wledge, deeth tion end/or inv	occurred at the ti estigation, in my	ime, dete end place opinion, deeth occu	e, end due to the arred et the time,	cause(s) and m date end plece,	enner es st and due to	teted. o the cause(s)
Mec	29b. Signature and title of certifier	trum		29c. Licen			29d. Date signe		
	Margudiell &	Diren on now	5000	111 71 2	D301	1/2	Derem	BAR	21 2/101
	36. Name and address of person who	completed cause of death (Item	23a) (Type, F	Print)	1 #3	of Gan	ters Bu	ec-u	21 2000
State	31. Dete filed (Month, Dey, Year)	32. negistrer's Signa	fure A	Sparks		, 97100	, , , ,		
strar	DEC 2 2 20	100 Seneva	10.	paysours					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

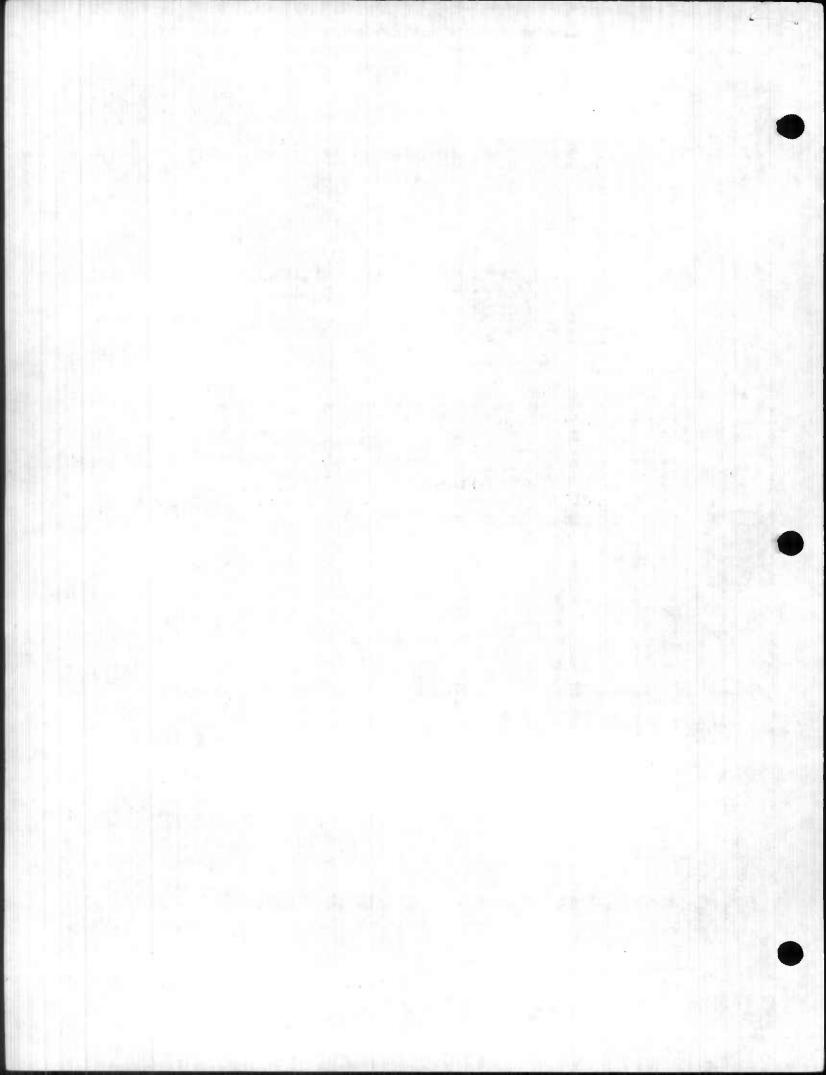
				Cei	tificate o	of Dea	th		Reg. No.	- F	I Q I
Physician /Medical	Decedent's Name (First, Midd ESTELLE	die, Last)		GREEN				2. Date of De Month DEC •		OÖÖ ^{ar}	3. Time of Death 4:20P.
Examiner	4a Facility Name (If not institution Washington A						oma Pa	ocation of Deat		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 055–18–0403	4□M offic		last birthday) 75 Yrs.	If Under 1 You Months Da		nder 24 Hrs. urs Min.	8. Date of Bi (Month, Di Sept.	18, 1925	9. Birthp Coun New	place (State or Foreign ntry) York
death with the Maryland ms 23a or 28a-f show remail be notified at	Usuel Residence of Decedent 10a. State 10b. Count Maryland Prince	ce Georges		ty, Town or Lo	cation						10d. Inside City Limits
or 28	10e. Street and Number			11 4 4	10f. Zip Cod	le	SILVE		10g. Citizen of V	What Cour	ntry?
020 urs after hr, or he bearding	8807 Enfield (11. Marital Status 1 Never Merried 2 Ma 3 Nover 4 Divorce	12. Was Dec Armed F rried 1 Yes	212 No		Wes Decedent t Yes, specify (of Hispani Cuben, Me		pecify Yes or No Ricen, etc.)	United 14. Rac Blac Specify	e - Americ ck, White,	can Indien,
T. s	15. Decede (Specify only high Elementery/Secondary (0-12) 12	nt's Education ast grade completed, College ((1-4or 5+)	16a. Deced (Give life. I	dent's Usual Oc kind of work do DO NOT use re laker	cupation one during tired)	most of wor	king	16b. Kind of B		dustry
ore, Maryland 212 ss 1 and 2 should be filed with the selb and Mantel Hygiene. If marked other than other traumatic event, pre. To Be Comp	17. Fether's Neme (First, Middle Harry		aifetz				lother's Nam Feiga	ne (First, Middle	, Maiden Sumen		weig
Mar end 2 sh selth end n 27 le m er traum	19a. Informant's Name/Relation Richard Stepha		son						per, City or Town, Airy, M		and 21771
0 2 - 2	20a. Method of Disposition 1	3 □Removal trom	State	Place of Dispo cemetery, crer	sition (Name o natory or other	f place)		Dete	20c. Location	City or To	own, State
Baltim. Pag permit. Pag Department Important: Pag any Injury once.	4 Donation 5 Dother (Specify) Mt. Lebanon Cemetery 12/22/2000 Adelphi, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, F 4400 Powder Mill Road Beltsville, M										
Physician /Medical	23a. Part1. Enter the disease, c shock, or heart tailure. Lis Immediate Cause (Final disease or condition	t only one carries on	caused the deal each line.								Approximate Interval Between Onset and Death
Examiner Examiner Examiner	resulting in deeth)			or es e consec							
x 68760, entiticate be executed ling physician and ee as the burial-trensit Medical Examin	Sequentially list conditions, if any, leading to immediate couse. Enter Underlying Cause (Disease or injury that initiated events	. A0	RTIC	VAL or es e conseq	JVE	RE	PLA	ce me	NT		
	resulting in death) Last	d									
P.O. hat the dd by the detached Physic	Part II. Other eignificant condit	ons contributing to d	RIE R				Part I.		Yes No		o the causa of death?
of Vital Records, Physician: The lew requires this certificate has been signeral director, page 2 should be call from the Completed by	ACUTE	REN	MAL	E	AILU	RE			s an autopsy ormed?	ev	Vere eutopsy tindings reliable prior to empletion of ceuse death?
Vital Rec	RESPIRA 25. Wes cese referred to medic	TORY	F	AILU	RE	26. 1	Place of Dea	1 □	Yes 2 No	1[□Yes 2□No
of Vita Physician: this certific ral director,	examiner?	Hospital:	Inpatient 2	ER/Outpatier	at 3□ DOA	Other:			idence 6 Oth	er (Specil	fy)
C p get o	27. Manner of Death Natural 5 Pend 2 Accident Invest	28a. Date (Mor ligation	ot Injury oth, Dey Year)	28b. Time of Injury		njury at Work? 1 🗌 Yes	2 🗆 No	28d. Describe	how injury occur	red	
	3 ☐ Suicide 6 ☐ Could	mined 200. Flac	e of Injury - At h ling, etc. <i>(Specil</i>	ome, farm, str	eet, factory, off	ice		28t. Location City or To	(Street and Numi own, State)	ber or Run	al Route Number,
Di ne Hospital or in 24 hours afte he Funeral Dir plately filled in edical Cert	29a. Certifier Cortifyi (Check only 2 Hedica	ng Physician: To the Examiner: On the b and mer	e best of my kno pasis of examina nner stated.	owledge, death	occurred et the vestigation, in r	e time, da ny opinion,	e end plece death occu	, end due to the rred at the time	ceuse(s) and m , date end place,	anner es s end due to	stated. o the cause(s)
To the com	29b. Signature abdalitle of portifi	7115	- il	10	29c. Lic	ense num	ber	96	29d. Dete signe	d (Month,	Day, Year)
10	30. Name and address of person	who completed cau	se of death (Iter	m 23a) (Type,	Print)	M			ROLL AU PARK, N		20912
State Registrar	31. Dete filed (Month, Day, Year DEC 2 2		Registrer's Signa	B.	pour	h					



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ician dical	Wayne	Francis	s Gonza						Month Decemb	per 12, 2	1117	19:42
niner	4a Facility Nama			t and numb	er)			4b. City, Town, or				
	5. Social Security	rgonne	ROad 6. Sax	7	Aga (In yrs.	last hirthday)	If Undar 1 Yaar	Baltin		N/A		lace (State or Foreign
al or	219-58-9 Usual Rasidence	878	ĭ X Û M		45	Yrs.	Months Days	Hours Min.		2, 1955	Washi	laca (Steta or Foraigr try) ngton D.C.
	10a. Stata	10b. County	у		10c. City	, Town or Loca	ation				10	0d. Inside City Limits
tor	MD	N/A			Ba	altimore						1 X Yas 2 □ No
Director	10e. Street and Number 10f. Zip					10f. Zip Coda			10g. Citizen of V	Vhat Coun	try?	
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Funeral	11. Marital Status		12. V	Vas Dacade	ent Evar in U.	S. 13. W	as Decedant of H	lispanic Origin? (S an, Maxican, Puar	Specify Yas or No		a - Amaric	an Indian,
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Compiered	(Sn		nt's Education			16a. Deceda	nt's Usual Occup	eatlon during most of wo	rkina	16b. Kind of Bu	siness/Inc	dustry
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5										, Maiden Sumam	18. <i>)</i>	
2	19a. Informant's I	e Gonza		Dain 61		10h Mailine	Addraga (Stead		nn Coffe		State Zin	Code)
				Print) 19b. Mailing Addrass (Street) 2803 Elnore						, MD 209		Coda)
	20a. Mathod of Di		V C Z / 1	OLO CIT	20b. P	laca of Disposi	tion (Nama of		Data	20c. Location -		wn, Stata
		Cramation		val from Sta	ata C	ematary, crami	atory or other pla		12/1/10	Dalhar	-111	MD
4 Donation 5 Dothar (Specify) Chesapeake Crematory, Inc. 12/16/00 Beltsvill 21. Signettine of Funeral Service Licenses 1 22. Nama and Address of Facility 22. Nama and Address of Facility									ille	, MD		
	22. Nama and Addrass of Facility CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, M											
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										an autopsy ormed?	av	are eutopsy findings allable prior to mpletion of causa daath?
	4-4-31								119	Yas 2 No		Yas 2□ No
e Completed	25. Wes case rate	arred to medica	al					26 Place of De	ath (Check only		16	2010
To Be	axaminar?		Hospi	tal:	etiant 2	ER/Outpatient	3 DOA Oth	nor:		idence 6 😡 Oth	er (Specif) at scene
n: T	27. Menner of Dec	eth	28	Ba. Data of					-	how injury occur		" at scene
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	1 Netural 2 Accident	7.7	tigetion	ound 12	Day Year) -12-00	28b. Tima of Injury 7:1:	5 M 1 🗆	Yas 2 No	unknown			
		dotor	not be mined 28	Be. Pleca of building	Injury - At ho	oma, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, Steta)	oer or Rura	al Routa Number,
3	3 Suicida 4 Homicida 6 Could not be determined 28e. Pleca of Injury - At homa, farm, street, factory, obuilding, etc. (Specify) found in building								2301 Argo	onne Drive	, Balt	co., MD
Certifical							occurred at the ti- estigation, in my o	ma, data and place opinion, daath occ	e, and dua to tha urred at tha ti <i>m</i> e,	causa(s) end me data end place,	enner es s and dua to	tated. o tha causa(s)
edical Certification:	29a. Cartifiar (Check only one)	1 Certifyi 2 Medicai	i Examiner: (and manne	r stated.			, in my opinion, daath occurred at tha tin				
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Medical Certifica	(Check only one)	20XMedical	i Examiner: (und manne	r stated.							
Medical Certifical	(Check only one)	Medical d titla of certification (er 20	w.k	W	23a) (Type, P	(D.C.M.E.				Day, Year) 3, 2000

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth **Physician** Month Edward Golden Sr. December 19, 2000 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Cuppett and Weeks Nursing Home 0akland Garrett 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Aga (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) **Funeral** Months Days Hours 214-07-0719 100 M 2□ F 95 Yrs. Director Usuel Rasidance of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examinar must be nothed at ms Ellerslie Director Allegany 1 □ Yas 2□ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ BOX USA 21579 items 23a Funeral death 12. Was Decedent Evar In U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours aftar of Department of Health and Mental Hyglene. Important: if item 27 Is marked other than "natural", or iter any Injury or other traumatic event, tre Medical Examinations. 1 ☐ Navar Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 Foreman 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Will (mnu) Golden M. Elizabeth Smith 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) Clarence E. Golden, Jr. Cumberland. MD 20b. Place of Disposition (Name of cematery, cremetory or other place) 21502 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 12-21-00 Cumberland, Md 21. Signeture of Funeral Servica Licensee 22. Nama and Address of Fecility Harvey H. Zeigler Funeral Home, Hyndman, PA 23a. Pert1. Enter the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Onset and Deeth Physician /Medical Immediete Causa (Final 21 years atherosclerotic cardiovascular disease diseesa or condition resulting in death) **Examiner** Due to (or es e consequence of): Examiner physician and the burial-transit The law requires that the death certificete be asscuted Saquentially list conditions, if eny, leeding to Immadiate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Physician/Medical Due to (or as a consequenca of): attending for usa as ate has been signed by the a pega 2 should be detached Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 ÃNo 3 Probably 4 ☐ Unknown senile onset dementia P 24b. Wara eutopsy findings aveilable prior to completion of causa of death? Be Completed 24e. Wes en eutopsy performed? 1 Tas 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica ataly tilled in by the tuneral director. 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4K Nursing Homa 5 Residenca 6 Other (Specify) Certification: To 1 ☐ Yes 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Deta of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? 1 XNaturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined within 24 hours after de To the Funeral Directo complataly tilled in by th 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Place of Injury - At homa, ferm, street, fectory, office building, etc. (Spacify) 4 Homicida 1 Certifying Physician: To the best of my knowladga, daath occurred et the tima, data end place, and due to the ceuse(s) and mannar as stated.

2 Medical Examinar: On the basis of axamination end/or investigation, in my opinion, deeth occurred et tha tima, data and place, and dua to the cause(s) end mennar stated. Medicai 29a. Certifian

To the

Baltimore, Maryland 21215-0020

P.O. Box 68760

Records,

Division of Vital

nes

State Registrar

Walter K. Naumann, M.D., PO Box 247, 106 Cemetery Rd, Accident MD 21520 31. Date filed (Month, Day, Year) DEC 2 0 2000

29b. Signetura and titla of certifier

32. Registrar's Signature

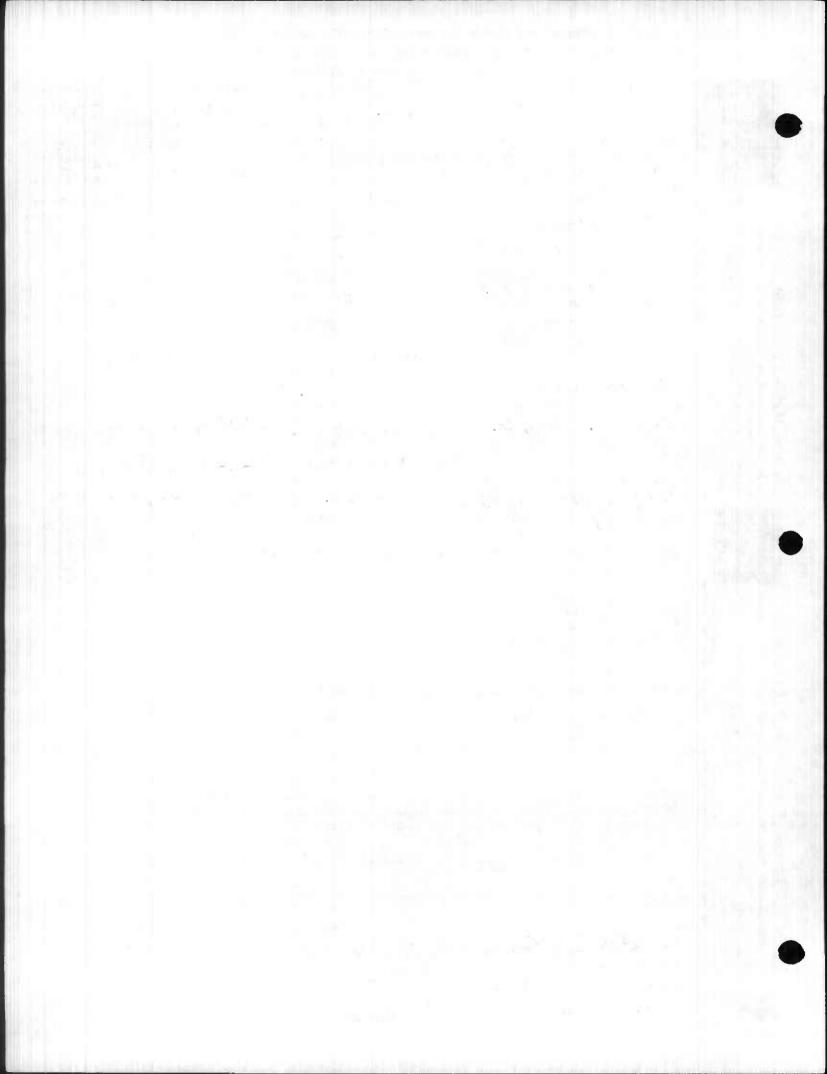
30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

D0025759

29d. Date signed (Month, Dey, Yeer)

December 19, 2000



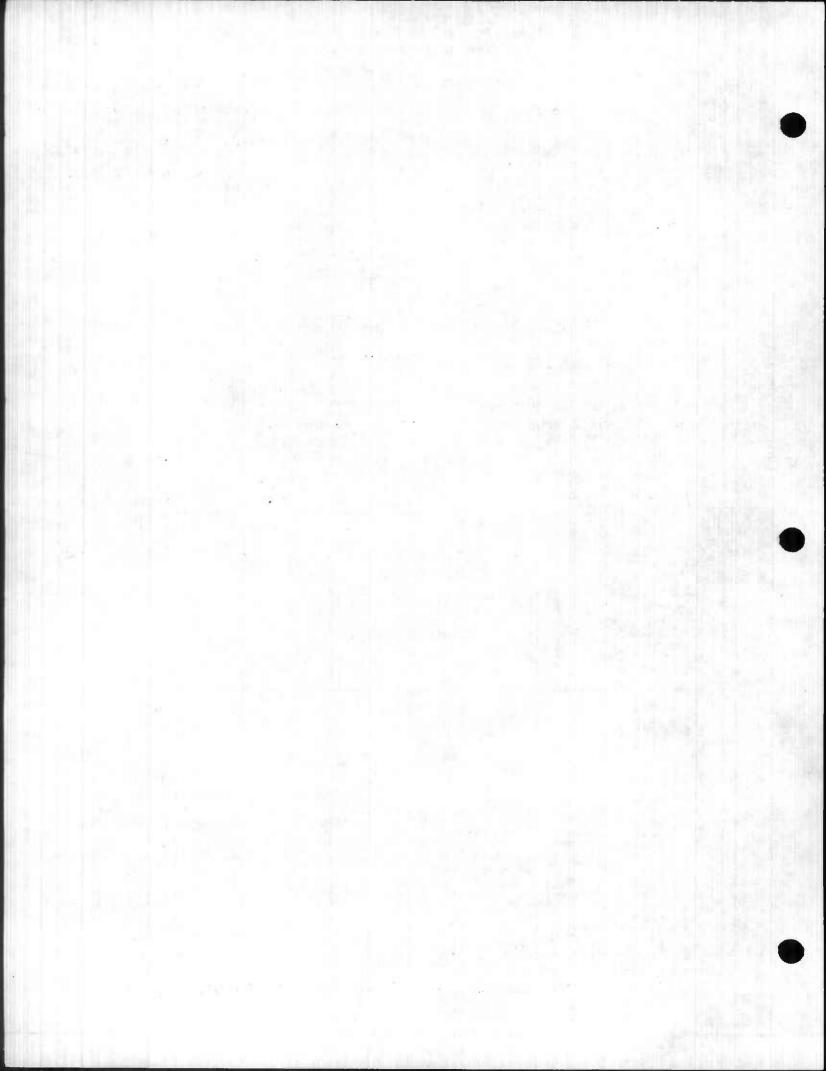
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Veer **Physician** 2000 Dorothy Spence Holt December 19 11:00 PM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Silver Spring 11 Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 3926 Wendy Lane Montgomery If Under 1 Vee 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Months 1□ M 2♥ F Vre Director 76 438-26-2748 Feb 10, 1924 0klahoma Usual Residence of Decedant deeth with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Madical Exemple: rough be notified at Silver Spring 10f. Zip Code 1 ☐ Yes 2 ☑ No Director Maryland Montgomery 10e Street and Number 10a. Citizen of Whet Country? 20906 3926 Wendy Lane Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Merital Status Bleck, White, etc. filed within 72 hours after 1 ☐ Nevar Merried 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hyglene. Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 Salesperson Retail is marked other permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 Is marked oths eny Injury or other traumatic event, page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be T.Y. Spence Belle Stookstill 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, Cify or Town, Stata, Zip Coda) Kyle M. Holt / Nephew 740 West Glebe Road, Alexandria, VA 22305 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Crametion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/21/00 Silver Spring, MD 22. Name end Address of Fecility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee ten Stile 500 University Blvd., W, Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or haart failura. List only ona cause on each line. Approximete Intervet Between Onset and Deeth **Physician** Immediata Causa (Finat disaasa or condition resulting in death) /Medical Metastatic Carcinoma of the Left Breast **Syears** Examiner Due to (or es e consequence of): Examiner The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events physician and the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): rasulting in deeth) Lest 88 attending p for use es signed by the a P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? should t Completed 24a. Wes an autopsy performed? hes 1 page Is certificata h 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital Physician: Be 25. Wes case rafarred to medicat examiner? 26. Placa of Daath (Check only ona) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 10 1 Yes 2 No this After this funeral c 28a. Dete of Injury (Month, Dey Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the Completely filled in by the tuneral 27. Menner of Deeth 28d. Describe how injury occurred Certification: tnjury et Work? 1 XNeturel 5 Panding investigation 1 Yes 2 No 2 Accidant Director: / 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At homa, ferm, straat, factory, office building, etc. (Specify) 4 Homicida 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) Medical and menner steted 29th Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Delly Mu LO D07285 December 20, 2000 nd addrass of person who completed cause of deeth (Item 23a) (Type, Print) James Brown, MD 9707 Medical Center Drive, Rockville, MD 20850

State Registrar 31. Dete fited (Month, Day, Year)
DEC 2 2 2000

32. Registrer's Sign

mercan



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month Dev **Physician** DEC. 19, 2000 5:15 AM FRANCIS HOFFMAN /Medical 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** THE HEBREW HOME If Under 1 Year ROCKVILLE MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Hours 100 101-22-0639 Director PA. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28a-f MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ð must be 238 6151 MONTROSE RD. 20852 Funeral U.S.A. 12. Was Decedent Ever in U,S. Amped Forces?

1 M Yes 2 □ No If Yes, Give Year or Dates: WWI Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married 21215-0020 ò 1 ☐ Yes 2 No Specify: þ Specify 3 ☐ Widowed 4 M Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementery/Secondery (0-12) College (1-4or 5+) BUSINESSMAN PRIVATE altimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fit iment of Heelih and Mental H tant: If Nem 27 Is marked off Be CHARLES ISIAH HOFFMAN FRANNIE BINSWANGER 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) STEVE BRAVY/STEPSON 19142 ROMAN WAY, GAITHERSBURG, MD. 20879 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlel 2 【**Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) ò CHAMBERS CREMATORY 12/19/00 RIVERDALE. MD. 22. Name end Address of Fecility 21. Signature of Funeral Service Liganus 5801 CLEVELAND AVE. -M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one course on each line. Approximete Intervel Between Onset end Death **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) SUDDEN Examine Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of) and Box 68760, Physician/Medical Due to (or es e consequence of) USB BS signed by the atter Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2010 3 Probably 4 Unknown Records. Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2DNG 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 VNo edicai Certification: To this funerel 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation after death. 1 Tyes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital owithin 24 hours of To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 5+1 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 0121 MONT 31. Dete filed (Month, Dey, Year)
DEC 2 0 32. Registrer's Signeture State 2000

DHMH 16 Rev 6/95

Registrar

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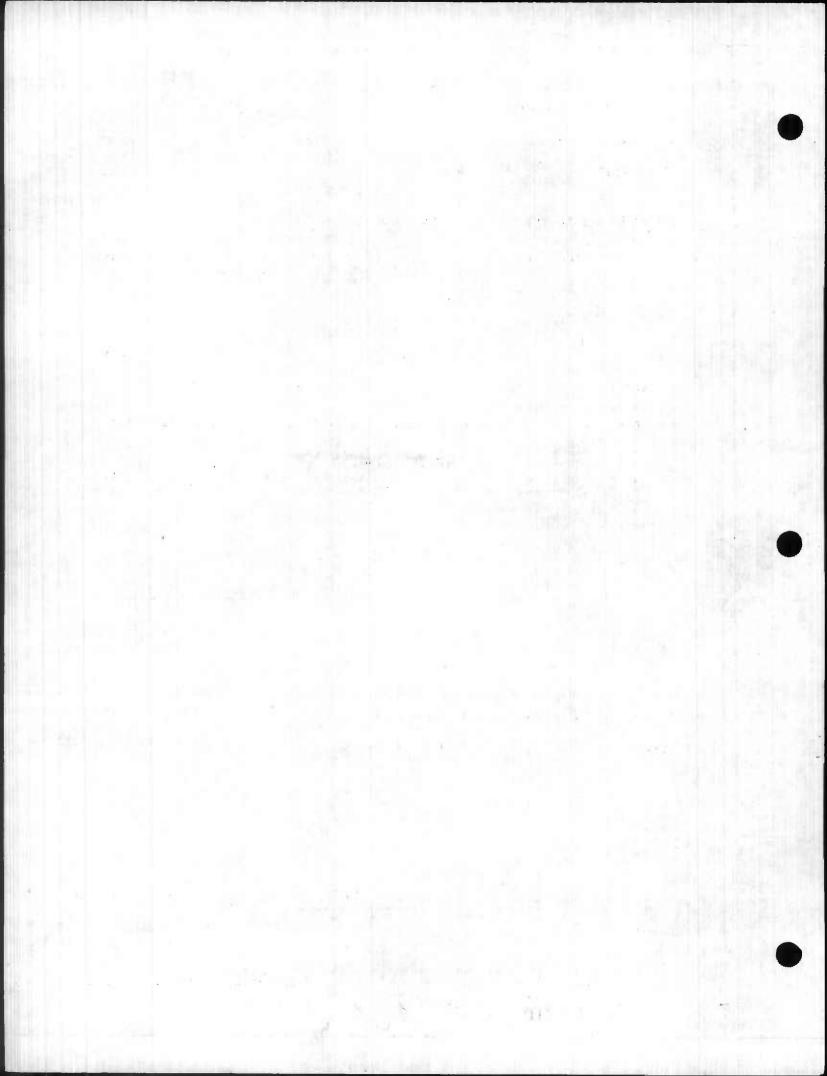
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Physician /Medical	Lawrence W. Hill:	yard				December	19, 2000	9:53 AM			
Examiner	4e Fecility Neme (II not institution, give s	treet and number)			4b. City, Town	, or Location of Dea	th 4c. County	of Death			
	Holy Cross Hospita	1			Silver			gomery			
Funeral Director	213-14-7193	7. Age (In yrs. 86	last birthdey) Yrs.	If Under 1 Ye Months Dey		Min. 8. Date of Bi	rth ey. Year) 1914	9. Birthplece (State or Foreig Country) Virginia			
Pu *	Usuel Residence of Decedent 10a. Stete 10b. County	10c City	y, Town or Lo	cation				10d. Inside City Limit			
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wher death with the Maryland r Heme 23a or 28e-f show other must be notified at Funeral Director	10e. Street and Number	<i>y</i>	- CHCI B	10f. Zip Code	9		10g. Citizen of V	Vhat Country?			
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hems 2 hems 2 her m		2. Wes Decedent Ever In U.	S. 13.			n? (Specify Yes or No Puerto Rican, etc.)		e - American Indien,			
Fu Fu	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: WW I		If Yes, specify C		Puerto Rican, etc.)	Specify	ck, White, etc. .: White			
natural",	15. Decedent's Educ (Specify only highest grade	ation completed)	16e. Dece	dent's Usuel Occ	cupetion	d working	16b. Kind of Bu	usiness/Industry			
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Mental H Mental H erked out etic ever	17. Fether's Neme (First, Middle, Last) Charles Edward Hil	lvard				Name (First, Middle ette Goli;		10)			
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s 1 and 2 should be filed if Health and Mental Hyy Item 27 is marked othe other traumstic event, TO BE C	19a. Informent's Name/Reletionship (Typ. Norman E. Shoemake					or Aurai Route Numb Rockville					
1 and 1 Health em 27 i	20e. Method of Disposition					Dete		City or Town, Stete			
8 = 2	1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State Dar	nestow	natory or other in Presb	yterian	December		eli O. H. Heller - N.			
permit. Pe Departmen Important: any Injury once.	4 Donetion 5 Other (Specify)	Chu	rch Ce	metery				own, Maryland			
Depa Impo eny l	21. Signatura of Funerat Soviet Company (22. Name and Addrass of Fecility Robert A. Pumphrey Ft Rockville, Inc. 300 West Montgomery A										
	M00689 Rockville, Maryland 20850–2805 23a. Fart Lines the disaese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and primary billium. List only one cause on each lina.										
Discontinuo	shoot or hadre eilura. List only on	e causa on eech lina.	n. Do not on	of the mode of t	lynig, saut 65 de	irdiac or respiretory	orrost,	Approximate Intervel Between Onset end Death			
Physician /Medical	Immediate Ceuse (Finel	A t - W	12 - 1	Trefores				1 Day			
Examiner	disease or condition rasulting in death)	Acute Myoca	r es e consac		.1011		-	1 Day			
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certifica iding ph isa es th											
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that the deeth ed by the atte detached for Physicia	Pert II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause	given in Pert I.	23b. Did	tobacco uae co	ntribute to the cause of deat			
hat the deby detac	Septic Shock, Hyox	emic Brain I	njury,	Acute 1	Renal	1	Yes 2 No	3 Probably 4 ₾ Unkno			
The law requires that the deeth certificate has been signed by the attending phyage 2 should be detached for use as it Completed by Physician/Med			410			24e We	s en eutopsy	24b. Wara eutopsy tinding			
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The law ate has page 2:							76	of death?			
Cate							Yes 2 No	1 ☐ Yes 2 ☐ No			
stotan: The lav certificate has rector, page 2 Be Comp	25. Was case referred to medical examiner?	ospitel: -x			Other	of Deeth (Check only		40. 41			
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tal or Attending P rs after deeth. at Director: After t led in by the funera Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he	oma, farm, str			28f. Location	(Street and Numb	per or Rurel Route Number,			
after Direction of the	4 Homicida	28e. Placa of Injury - At he building, atc. (Specify	y)			City or To	iwn, Stete)				
To the Hospital or Attending Physician: white 24 hours after deals as after deals To the Funeral Director: After this certifica completely filled in by the funeral director, Medical Certification: To Be (clan: To the best of my knower: On the basis of examine end manner steted.									
Neithin Sompl	29b. Signefure and title of certifier	0		29c. Lice	ense number		29d. Dete signe	d (Month, Dey, Year)			
10+1	1 Mertin C	Shang O &	0	D08	3944		December	20, 2000			
10	30. Neme end address of person who cor	npleted cause of deeth (Item	1 23a) (Type.	Print)							
	Martin C. Shargel,	MD., 3720 Fa	rragut	Avenue	, Kensir	ngton, Mar	yland 20	0895-2110			
State	31. Dete filed (Month Day, Year)	32. Registrer's Signe		- 4							

Registrar



Lawise Viola HENDRICKSON

		State of I	Maryland / Dep	partment of hertificate of			ne U	42157		
	1. Decedent'a Name (First, Mid	die, Last)				₹. Deta of Death	. 110.	3. Time of Death		
Physician /Medical	Louise Vic	ola Hendric	ekson			Accembe	16.	2000 1:351		
Examiner	4a Facility Nama (If not instituti Doctors Commun				4b. City, Town, or Lo		4c. County	ince George's		
Funeral Director	5. Social Security Number 024–20–3213	6. Sex 7.	Age (In yrs. last birthda 84 Yrs.	y) If Undar 1 Yaar Months Days		8. Data of Birth (Month, Day, Y July20, 1	ear) 916	9. Birthplaca (State or Forei Country) Massachusetts		
thow it	Usual Residence of Decedent 10a. State 10b. Count		10c. City, Town or					10d. Inside City Limi		
or 28a-f shows northed at	Maryland Prince	ce George's	Greenbe	10f. Zip Code		100	. Citizen of W	1 Yas 2 □ P		
ms 23a or 28a-f show croust be notthed at neral Director	22 Ridge Road	, #238		207	70			d States		
P. P.	11. Maritai Sfatus 1 Never Married 2 Ma 3 Widowed 4 X Divorce	W 172 . O	nf Evar in U,S. 13 s? □ No s:1945–1946	3. Was Decedent of H If Yas, specify Cub	Hispanic Origin? (Spean, Maxican, Puarto Specify:	ecify Yas or No- Rican, etc.)		a - American Indian, k, White, etc. :: White		
- 2	15. Decede (Specify only high Elementery/Secondery (0-12)	ent's Education lest grada completed)	16a. Dec	cedent's Usual Occup ve kind of work done b. DO NOT use retire	pation during most of works	b. Kind of Bu	siness/Industry			
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ind Mental Hygie in marked other umatic event, tr	17. Fathar's Nama (First, Middle William		ton			(First, Middle, Ma L• Fergu		θ)		
ith and Mer 27 la marke r traumatic To	19a. Informent's Neme/Relation Jacqueline Her				tand Number or Rure ehall Driv			Stete, Zip Code) Maryland 207		
int: If Hem iry or other	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) Maryland Veterans Cemetery 12/20/00 Crow									
Department of Heelth as Important: If item 27 is any Injury or other traconce.	21. Signatum of Funeral Service	e Licenses	uolt.	22. Name and Address Donald V. 4400 Powde	Borgward	t Funeral	Home,			
hysician /Medical examiner	23a. Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in deeth)	aCo	ngestive Due to (or es a cons	0	farler			Interval Between Onset and Death		
ertificate hes been signed by the ettending physicien and ector, page 2 should be detached for use as the bunal-transit.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disesse or injury that initieted evants resulting in death) Last	6	Due to (or as a cons Comman Dua to (or as a cons Remail	sequence of):	Eny de	rease		Years Years		
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been signed by the ettending p should be detached for use as leted by Physician/Mee	, ,	ger Einster		rasul o			2□ No	3 Probably 4 Unkn		
s been sig 2 should b	0					24a. Was an a performe	autopsy d?	24b. Were autopsy finding available prior to completion of cause of death?		
E S			3.11:7			1 ☐ Yes	212 No	1 ☐ Yes 2 ☐ No		
a a S	25. Wes case referred to medic	Hospital:	atient 2 ER/Outpat	ient 3 DOA Ot	hor	h (Check only one)	. 50			
certificata hes rector, page 2 Be Comp	examiner?	1 le Inpi	me 5 Residence 28d. Describe how							
th. After this certificata funeral director, par tion: To Be Co	1 Yes 2 No 27. Manner of Death 1 Netural 5 Pend	28a. Date of li (Month, stigation	Day Year) fnjun		Yes 2□No					
after deeth. Director: After this certificata d in by the funeral director, par ertification: To Be Co	1 Yes 2 No 27. Manner of Death 1 Netural 5 Pend 2 Accident inves 3 Sulcide 6 Could	d not be	Injury - At home, farm, etc. (Specify)	M 1	Yes 2□No	28f. Location (Stre City or Town,		er or Rural Route Number,		
ther this ouneral direction. To	1 Yes 2 No 27. Manner of Death 1 Netural 5 Pend 2 Accident inves 3 Suicide 6 Coult 4 Homicide 29a. Certifier 1 Certify	d not be	Injury - At home, farm, etc. (Specify) st of my knowledge, de- of examination and/or	M 1 street, factory, offica	Yes 2 No	City or Town,	Stata) se(s) and ma	er or Rural Route Number,		

State Registrar

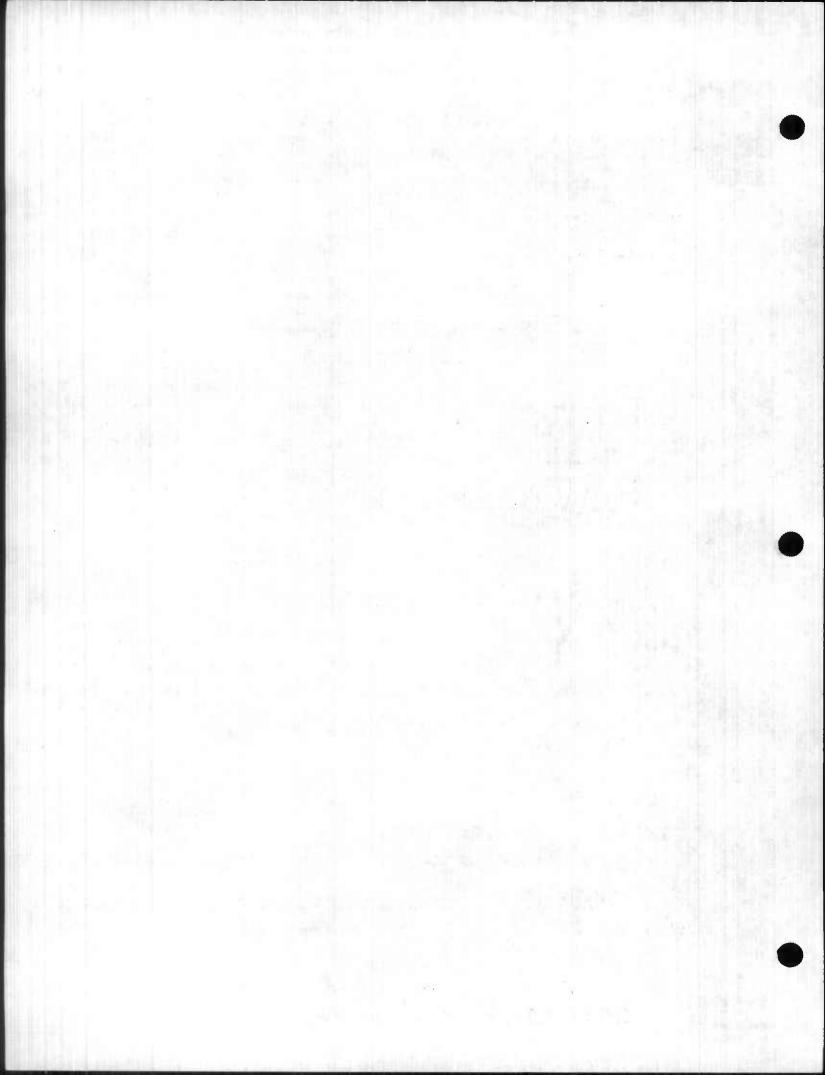
DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

DEC 1 9 2000

32. Registrar's Signatura

Sporks



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Rita W. Harden December 13, 2000 2:40 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Layhill Center/Genesis Healthcare Silver Spring Montgomery If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) tf Under 1 Year Birthplace (Stata or Foreign Country) **Funeral** Days 1 M 2 F Months 182-14-1635 78 Director July 6, 1922 Pennsylvania Usual Rasidanca of Dacedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò Itams 23a 15201 Elkridge Way, #3-E 20906 USA Funerai deeth 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. d 2 should be filed within 72 hours after the and Mental Hygiene.
7 Is marked other than "natural", or its traumatic avent, the Medical Emerica 1 ☐ Nevar Married 2 ☑ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17 Fathar's Nama (First Middle Last) 18 Mothar's Nama (First Middle Maiden Sumema) Peges 1 and 2 should be fit ment of Heelth end Mental Hant: If item 27 is marked oth jury or other traumatic aven Be Daniel Glen Walter Rose Ann McNelis 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) James B. Harden / Husband 15201 Elkridge Way, #3-E, Silver Spring, MD 20b. Place of Disposition (Nama of cemetary, cremetory or other plece) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify Gate of Heaven Cemetery 12/18/00 Silver Spring, Maryland 22. Nama and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland ns that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediata Causa (Final disaase or condition resulting in death) 3 wks /Medical neumonia Examiner Due to (or as a consequence of): Sequantially list conditions, if any, laading to immadiate cause. Enter Undarlying Cause (Disaase or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Physician/Medicai the Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No Probably 4 Unknown þ 24b. Ware eutopsy findings available prior to completion of cause Completed 24a. Was en eutopsy 1 Yas 2 No

Box 68760. P.O. Records, Division of Vital Hospital or Attending Physician: Be Medical Certification: To this Affer To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After a completely filled in by the fun

25. Was casa rafarrad to medical axaminar? 1 ☐ Yes

27 Manner of Death Matural 5 Pending

2 Accidant invastigetion 6 Could not be determined 3 ☐ Suicida 4 Homicida

29a. Cartifiar

Certifying Physician: To tha best of my knowledge, deeth occurred at the tima, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of axaminetion and/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and mannar stated. 29b. Signatura and titla of cartifiar Wilteman

28a. Data of Injury (Month, Day Year)

29c. License number D45285

28c. Injury at Work?

1 Yes 2 No

26. Placa of Daath (Check only ona)

Other: 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Data signed (Month, Day, Year)

30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

Ningle 344 UmiVersity

Rhod, # 113, Silver spring, Md 2090

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

State Registrar 31. Data filed (Month, Day, Year) **DEC 18** 2000 32. Registrar's Signatura

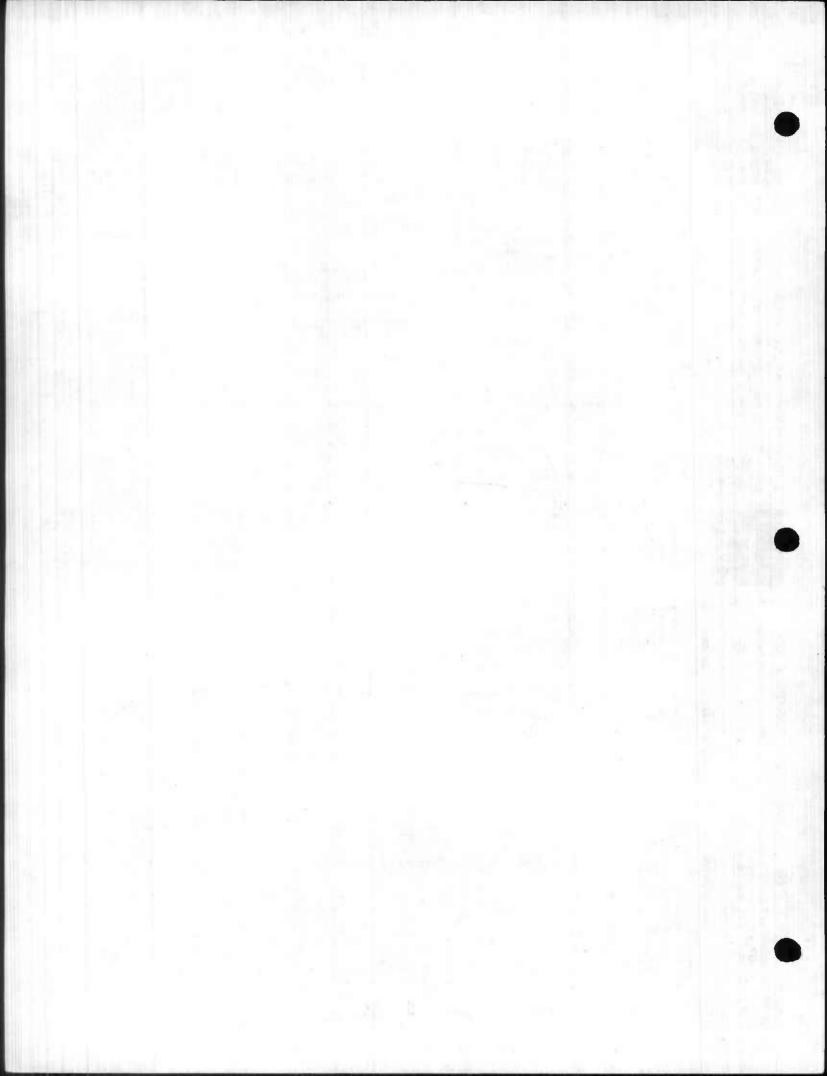
1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28b. Tima of

oaks

15



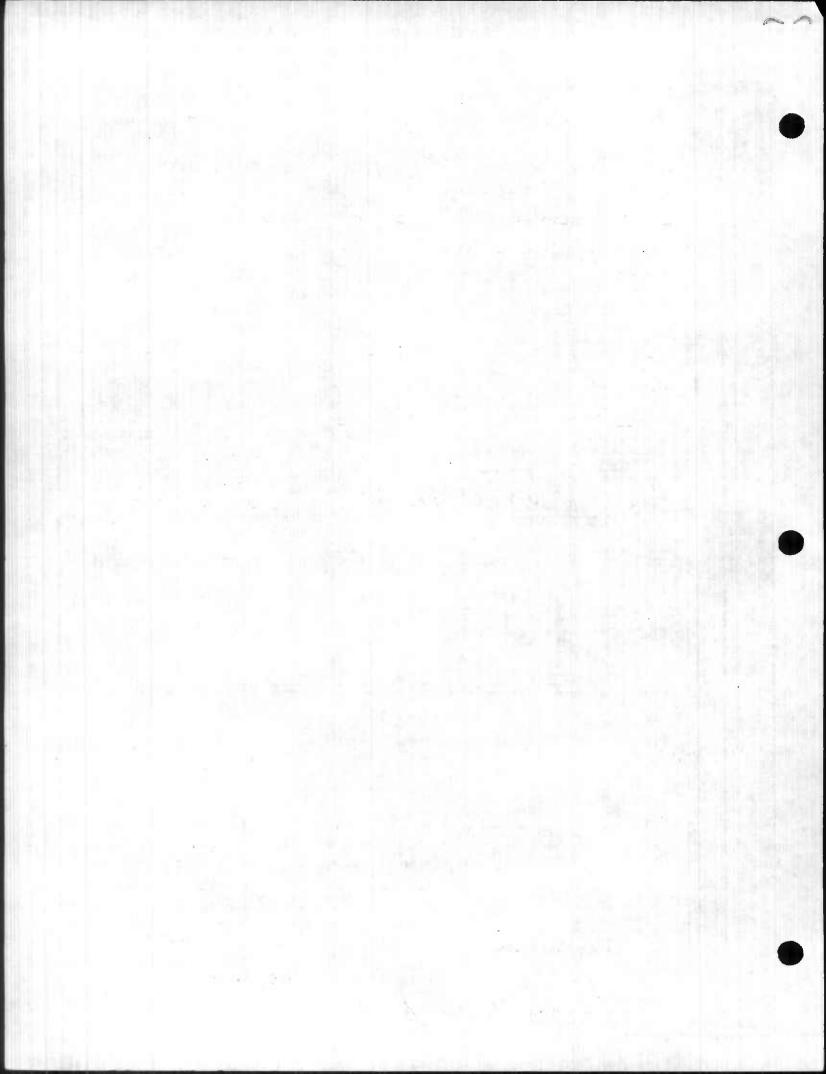
John	Wesley	Hall	State of Maryland		ment of I icate of			giene Reg. No.	42	159		
	Physician /Medical	1. Decedent's Nama (First, Middla, Las JOHN WES					2. Data of Dec	ath ER ^D 199, 20	000	3. Time of Death 10:42 P.M.		
	Examiner	4a Facility Nama (If not institution, give EASTBOUND LANE O	street and number) F MONTGOMERY AV	ENUE		4b. City, Town, or GAITHERS	BURG		of Death	ERY		
	Funeral Director	5. Social Security Number 6. Security Number 219-78-4267	7. Aga (In yrs. la 3. Aga (In yrs. la		Under 1 Yaar onths Days	If Undar 24 Hrs Hours Min	(Month, Da	y, Year) 4,1960	year) ,1960 9. Birthplace (Sta			
May and May an	or 28e-f show be notified at Director	Md Montgo		Town or Location	ery V	illage				0d. Inside City Limits 1⊠ Yas 2 ☐ No		
A CIA	23a or 2 at Dire	100. Street and Number 10026 Stedwi	ck Rd, # 304		01. Zip Coda 20886			U.S.A	/hat Coun	itry?		
5-0036 72 hours effer death with the Maryland	at', or items 23. Example: man	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	10026 Stedwick Rd, # 304 11. Marital Status 1 Nevar Married 2 Married 12. Was Decedent Evar in U.S. Armed Forces? 1 Nevar Married 2 Married 1 Nevar Married 2 Married 1 Nevar Married 2 Married				Specify Yas or No- to Rican, atc.)		k, Whita,	an Indian, atc. lack		
215-0	yglane. ser than "naturn t, ize Medical Completed	15. Decedent's Ed (Specify only highast grad	da complated)	16a. Decedent's (Giva kind life. DO N	s Usual Occup of work dona NOT usa retire	pation during most of wo d)	rking	16b. Kind of Bu				
d 212	The o	Elementery/Secondery (0-12) 12th Grade 17. Fathar's Nama (First, Middla, Last)	Collega (1-4or 5+)	Cust	odian		ma (First, Middle,			nty Schl		
arylar ehould be	th and Mental Hyr 7 Is marked othe traumatic avam, To Be C		mpson			Amel		dman		20006		
, Mar	Health and Mental am 27 la marked o ther traumatic av	19a. Informant's Name/Ralationship (7 Annette Hall B								20886 lage, Md		
Baltimore, Maryland 21215-0036	Department of Haalit Important: If Itam 27 any Injury or other to bncs.	20a. Method of Disposition 150 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of cematary, cramefory or other place) Ash Memorial Cem. 12/16/00 Sandy Spr.										
	hysician /Medical xaminer	23a. Part1. Enter the disaasa, or curing shock, or haer failura. List cyly of immediata Causa (Final disaasa or condition resulting in daeth)	aMULTIPLE	INJU:	RIES					Intervel Between Onset and Death		
ecords, P.O. Box 68760, law requires that the death certificate be executed.	d by the attending physician and lateched for use as the burial-tranait. Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediata causa. Enter Undartying Cause (Disease or injury that initiated evants rasulting in death) Last	с	as a consequand								
P.O. B	been signed by the attending p should be datached for use as:	Part II. Other eignificant conditions co	ntributing to death but not rasult	ting In tha undar	lying causa gi	van in Part I.				the cause of death?		
Division of Vital Records, or Attending Physician; The law requires to	page 2 should be c							an autopsy med?	av	ara autopsy findings ailable prior to mpletion of causa death?		
Tal H	cartificate he rector, page	25. Wes case ratarred to medical				40 Bl		Yas 2□No	0	Yas 2□ No		
of Vital R	arthis cartific aral director, n: To Be	axaminer? 1 ⊠ Yas 2 □ No 27. Mannar of Death		P/Outpatient 3	BDOA Ot	har: 4 Nursing	ath <i>(Check only c</i> Homa 5□ Rasio 28d. Dascribe			SCENE		
Vision	n 24 hours after death. The funeral Director: After the platety filled in by the funeral edical Certification:	1 Natural 5 Panding 2 Accident invastigation 3 Suicida 6 Could not be 4 Homicide datarmined	Dec 9,2000	10:42 P	M 1	Yas 22No		CK by		al Routa Number,		
O pitalo	within 24 hours after de To the Funeral Directo complately filled in by ti Medical Certific			treet			Gaith	ersbur				
Ne Hos	in 24 h he Fun plately edica		Iner: On the best of my know and mannar stated.	on and/or Investi	gation, in my	opinion, deeth occ	urred et the time,	dete and place,	and due to	o tha ceuse(s)		
10 10	To the com	29b. Signification and title of certifile	and		29c. Lican O.C.	M . E .		29d. Data signe DECEMBE	(Month, R 10,	Day, Year) 2000		
		30. Name and address of person who of J. Laron Locke M.	111	23a) (Type, Print L Penn S	Street,	Baltimo	re, Mary	land 21	201			

State Registrar 31. Data filed (Month, Day, Year)

DEC 2 1 2000

32. Registrar's Signatura

ports



					State	of Ma	aryland		rtment of		ealth and M Death		giene Reg. No.	42	2160
	BAT III		1. Decedent's Nem	e (First, Middle	, Last)							2. Dete of De		Vans	3. Time of Death
П	Physicia /Medic		PATRI	CIA ANN	HAWKIN	S						Month Decembe	er 22,	2000	15:15
	Examin		4a Facility Nama (I	f not institution,	giva street and	n <i>umber)</i>		-		41	b. City, Town, or Le	ocation of Deet	h 4c. Cou	inty of Deet	h
н			SACRE	D HEART	HOSPIT	AL				C	UMBERLANI)	ALL	EGANY	
	Funeral Director		5. Sociel Security N 219 34 6	570	6. Sex 1 □ M 2 F	-	6 (In yrs. le:	st birthday) Yrs.	If Under 1 Ya Months De		If Undar 24 Hrs. Hours Min.	8. Dete of Bir (Month, De SEPT 2	th by, Year) 0 1938		hplece (Stete or Foreign untry) YLAND
	2 .		Usuel Residence of 10a. Stefe	Decedent 10b. County		1	10c City	Town or Loc	eation						10d. Inside City Limits
	ith with the Marylar 23e or 25a-f show ust be notified at	5	MARYLAND		NTSZ				Allon						1 ☐ Yes 2 No
	No No Market	Director	10e. Street and Nur	ALLEGA	INI		FRUS	TBURG	10f. Zip Cod	la			10g. Citizen	of Mines Co	
	6 8	ä	17611 OL		ROCK R	OAD	CLI		2153						untry r
	10 mm	era		D DAM S				42.14			annia Odrina (Ca	neifu Van av Na	U.		rican Indien,
	lterr di	Funeral	11. Marifel Status 1 ☐ Never Merri	ind 2X Marris	Armed	Forces?	Ever in U,S	IS. VI	Yas, specify C	Cuber	spenic Origin? (Sp n, Maxican, Puerto	Rican, etc.)	13.1	Black, White	
38	rs af	by F	3 Widowed		If Yas,	GiveXX	10	1	☐ Yes 2【X	No	Specify:		Spe	city: W	HITE
21215-0036	72 hours netural, dical Exa			15. Decedent'	1	Dotos.		16e Deced	ent's Usuel Oc	cuna	fion		16b. Kind o	f Business/	industry
5	in 72	Completed		rify only highest	grade complete		16e. Decedent's Usuel Occupation (Give kind of work done during most of wo				uring most of work	ing			
212	the the	E	Elementery/Seco	ndary (0-12)	College	e (1-4or 5	+)	CAFET	ERIA M	AN	AGER		SCHO	OL	
	H PER	Bec	17. Fethar's Nema	(First, Middle, L	ast)						18. Mother's Name	e (First, Middle	, Maiden Sun	neme)	
a	lid be lented fe ev	ToB	JOHN LEO	BEAN							MARY I	KEILING			
Maryland	and M	-	19a. Informent's Na	ame/Reletionsh	ip (Type, Print)			19b. Meilin	g Address (Str	reet e	and Number or Rur	rel Route Numb	er, City or To	wn, Stete, 2	Zip Code)
ž	27192		WILLIAM H	AWKINS	/ HUSBA	ND		17611	OLD D	AN	'S ROCK I	ROAD, SI	W, FRO	STBUR	G, MD 21532
re,	- He de		20e. Method of Disp		9,431		20b. Ple	ce of Dispos	sition (Neme of atory or other	f	a)	Data	20c. Location	on - City or	Town, Stete
Ë	Page anio mini		1 Buriel 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) FROSTBURG MEMORIAL PARK 12/26/00 FROSTBURG,										BURG.	MD 21532	
Baltimore	ortan Inju		21. Signature of Fureiral Service Licensee 22. Name and Address of Facility												
ã	Page 18		DAUGO 1	11 Same	0						ERAL HOM) (D) (1)	1522	
			23a Part1 Enter th	h disease of	complications the	et caused	the deeth.				ST., FR			1532	Approximata
	Diversity in the		23a. Part 1. Entar to shock, or bea	rt failule. List o	nly one ceuse o	n each lin	10.	Do not onto		ay in ig	, 000,100 00,000	or roop notory o		1	Approximata Intervel Between Onset end Death
	Physician /Medical		Immediata Cause (Finel	1			,	1 1	,					11.
	Examiner		diseese or condition resulting in death)	n	a. M.	roxi	c enc	copha)	opath	y		_		-	4days
		e e			/		O HEID SE	1		1	rent			1	Adays Alays Adays
	uted ansit	Examiner			b			mon q		1//	9/				-100195
,	execut in and riai-tran	Exa	Sequentielly list con if eny, leeding to im- cause. Enter Under	nditions, nmediete		01		1	de an a					1	Adors
760,	e be rsicia	cal	thet initieted events	injury	c		non a	Z a consecu	July July					1	1001/5
68	ificat g phy as th	8	resulting in death) I	Last				/- /	Into	1	ti			1	Adays
Box 68	ndin use	2			d	July	0691	Mal	11/0	9/	0/100				1-0-//
0	death d for	by Physician/Med	Part II. Other signif	icant condition	ns contributing to	death bu	it not result	ting in the un	derlying cause	a give	en in Part I.	23b. Did	tobacco use	contribute	to the cause of death?
P.0.	by the	hy								3		10	Yes 2EN	lo 3□P	robably 4 Unknown
, E	s the	y P	Dia	9070	melliju)	1741	erica	J (01						
ď	r requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunat-transit	B	11	. /:	mellitu								an autopsy		Were eutopsy findings evailable prior to
00	w rec	Completed	17/10	11 feed	M/9							peni	omea r		completion of cause of death?
Re	he lew e has	E										10	Yes 250N		1 Yes 2 No
ta	ffication, pe		25. Wes case refer	red to medical							26. Plece of Deel				10103 2010
>	or Attending Physician: The lew after death. Director: After this certificate has b i in by the funeral director, page 2 s	To Be	examiner?		Hospitel:	Prinnetie	ot 2DE	R/Outpatient	3□ DOA	Othe				Other (Sne	cifu)
o	Phy or this		27. Menner of Deeti	h	28a. De	ete of Injur	y 2	28b. Time of	28c. I	Injury		28d. Describe		-	o.i.y,
o	ith. : Afte	흥	1 Netural 2 Accident	5 Pending investig		fonth, Day	(Year)	Injury			Yes 2 No				
Division of Vital Records,	Attendi r deeth. ector: A	Hice	3 Sulcide	6 Could no	ned 200. Pil	ece of Inju	ıry - At hoл	ne, farm, stre	et, fectory, offi	ica				umber or Ri	ural Route Number,
á	P 등 다 등	Certification:	4 Homicide		bu	iliding, etc	: (Specify)				JI ST	City or To	wn, State)		
	To the Hospital or Attending Physician: The I within 24 hours after deeth. To the Funeral Director: After this certificate hi completely filled in by the funeral director, page		29e. Certifier								e, dete end plece,				
	Ho Ho He Fu	edical	(Check only one)		xaminer: On the		examinetic				pinion, deeth occur				
	To th To th	M	29b. Signature and	title of certifier	10	0		2	29c. Lic	anse	number		29d. Dafa si	gnad (Mont	h, Day, Year)
			10	hon	-18	la	mo		02	2	1488	1	Decemb	er 22	, 2000

40 State

Registrar

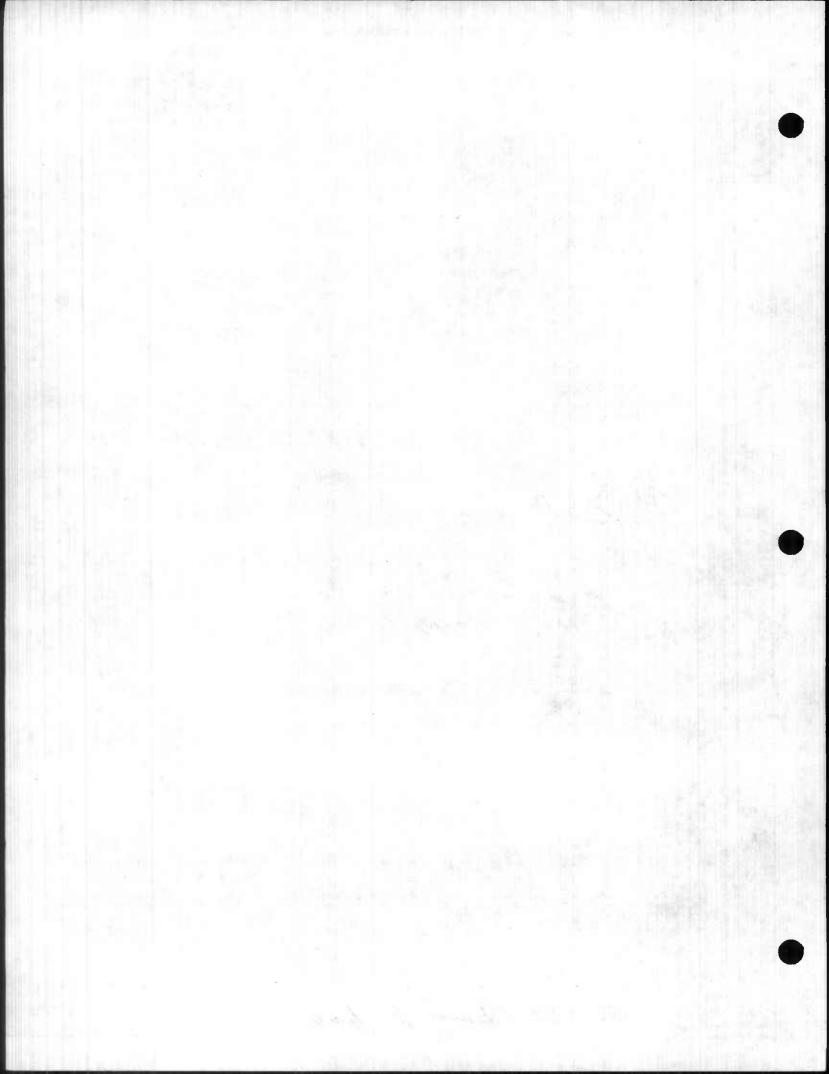
30. Nama end address of person who completed causa of death (Item 23a) (Type, Print)

Thomas Devlin MD, 20 Douglas Ave. Lona coning, ms. 21539

31. Data filed (Month, Dey, Year)

DEC 2 6 2000

Serve B Sparsh



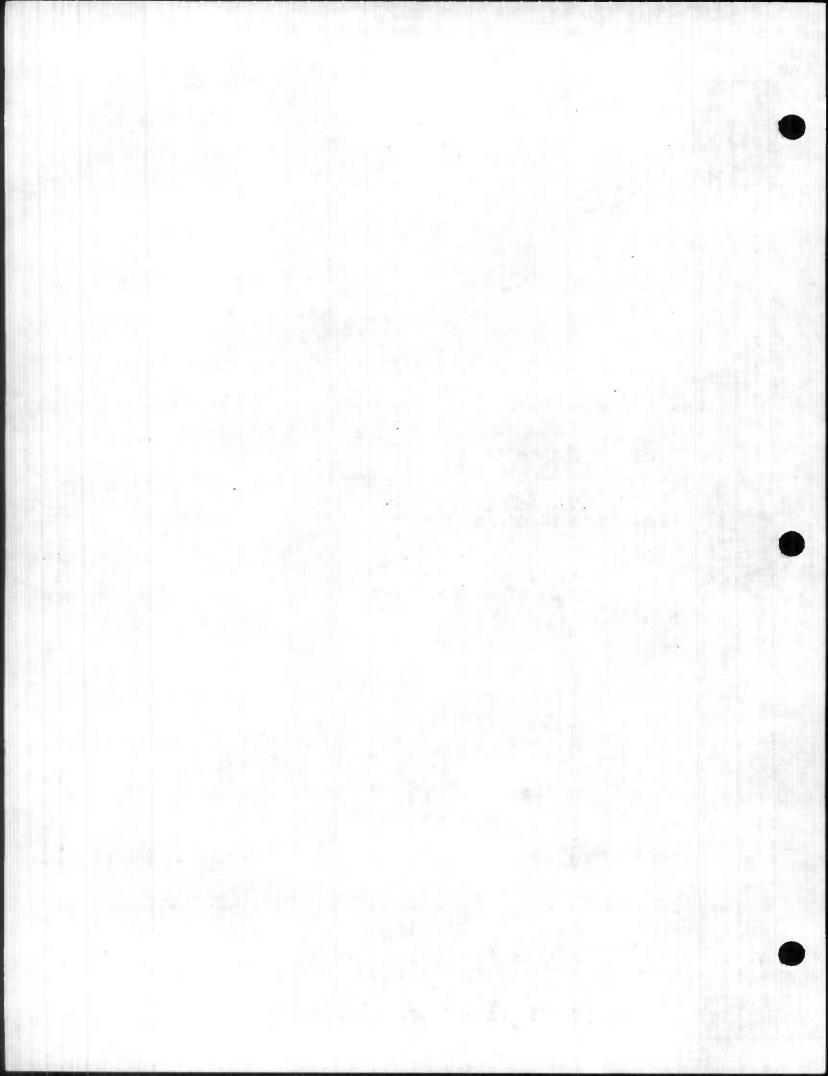
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Yaar **Physician** Michael Fitzroy Joseph December 17, 2000 1:30 pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice- Casey House Rockville If Undar 24 Hrs. Montgomery 5. Social Security Number If Under 1 Yaar 6. Sex 1 → M 2 □ F 7. Aga (In yrs. last birthday) Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 33 Director 213-11-8550 Dec 22, 1966 DC Usual Rasidence of Decedent the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. fnside City Limits "natural", or items 23a or 28a-f show 1 Yas 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Peges 1 and 2 should be filed within 72 hours after deeth with nent of Health end Mental Hygiene.

It is flam 27 is marked other than "natural; or thems 23a or marked other than instituted the marked other handle." 2527 Ross Road #101 20910 Funeral USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Montgomery County Dept College (1-4or 5+) Elementery/Secondary (0-12) 4 Library Assistant of Public Libraries 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) John Fitzroy Joseph Carolyn Juanita Brown 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2527 Ross Road #101, Silver Spring, MD 20910

a of Disposition (Nama of Data 20c. Location - City or Town, Stata Indira Anne Kingry/ Wife 20b. Placa of Disposition (Nama of cematery, cramatory or other placa) 20a Method of Disposition permit. Peges
Department of
Important: If it
any injury or c 1 Burial 2 Cramation 3 Ramoval from Stata Gate of Heaven Cemetery 12/20/00 Silver Spring, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funaral Sarvice Licenses 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complication; that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one crucia on each line. Approximate interval Between Onset and Death Physician /Medical Immediata Causa (Final disaasa or condition resulting in death) Metastatic Lymphoma 5 months Examiner Dua to (or as a consaquanca of): Physician/Medical Examine Non-Hodgkins Lymphoma 18 months attending physician end for use as the burial-transit the deeth certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequanca of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consequanca of): signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 XNo 3 Probably 4 Unknown É 24b. Ware autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed certificate has b lirector, pege 2 s 1 ☐ Yas 2 ☐XNo 1 Yas 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) To Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6X Othar (Specify) Hospice 1 ☐ Yas 2 ☑ No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datermined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28a. Placa of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 4 ☐ Homicide 110 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mennar stated. 29a. Certifier edicai (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cartifiar D09470 December 18, 2000 30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print) 10400 Connecticut E.P. Libre, MD Ave., Kensington, MD 20895 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State **DEC 1 9** 2000 Registrar

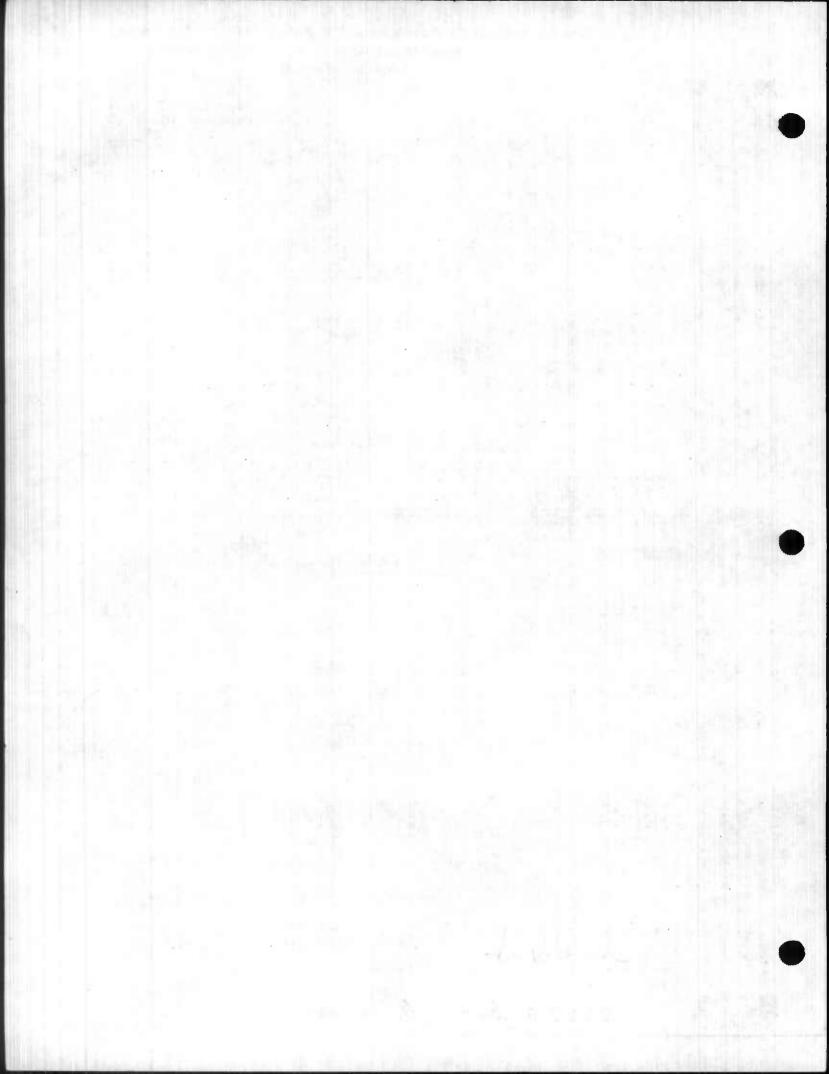


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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) December 15, 2000		Woo	29b. Signature and title of certifier	afun		2	9c. License				

State Registrar

Anushiravan Dadgar, MD
31. Dete filed (Month, Day, Year)
DEC 1 9 2000
32.

13219 Executive Park Terr., Germantown, MD 20874



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month December 19, 2000 Werner Lutz 2:25 AM Janney 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street and number) 4c County of Death Montgomery General Hospital 01ney Montgomery If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) Months Days Hours Min 1₺ M 2□ F Yrs. 88 Oct. 19, 1912 Virginia 225-14-2068 Usual Rasidanca of Dacadan 10a State 10b. County 10c. City. Town or Location 10d. insida City Limits 1 ☐ Yas & ☐ No Maryland Montgomery Sandy Spring 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? 17340 Ouaker Lane 20860 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, etc. 11. Marital Status 1 Naver Married 2 Married 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Editor Magazine 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Asa Moore Janney Blandina Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Numbar, City or Town, State, Zip Code) Katherine Janney / Daughter 603 Smallwood Road, Rockville, Maryland 20850 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Chesapeake Crematory 12/21/00 Beltsville, Maryland 21 Signature of Funeral Service Lic 22. Nama and Address of Fecility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue 23a. Part1. Enter the diseasa, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat end Daath Immediata Causa (Final disaasa or condition rasulting in death) (Troin-Sequantially list conditions, if eny, leading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting In the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to 24a. Wes an autopsy performed? complation of ceusa of death? 2 [LN 1 Yes 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 ☐ Yas 25 1 10 1 Diripatiant 2 ER/Outpatient 3 DOA

Examiner requires that the death cartificete be executed attending physician end for use as the bunal-trans Box 68760 Physician/Medical 88 signed by the a Division of Vitai Records, P.O. by Completed been s The law page 2 has certificete Physician: Be 2 After this funaral Certification: Attending I Director: Af aftar death.

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Physician

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7 is marked other than "natural", or items 23e or 28a-f ehow traumatic event, the Medical Examiner must be not fired at

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event place.

Physician dilegica

Examiner

Maryland 21215-0020

Baltimore,

/Medical

Directo

Funeral

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Completed

25. Was casa rafarrad to midicel examiner?

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Cartifian

4 | Homicide

(Check only one)

5 Pending invastigation

28a. Data of Injury (Month, Day Yaar) 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tas 2 No

28d. Dascribe how injury occurred

28f. Location (Straet and Number or Rural Routa Number, City or Town, State)

Certifying Phyalcian: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, date and place, and due to the causa(s) and mannar stated.

29b. Signatura end titla of certifiar

29c. License number D50678 29d. Data signad (Month, Day, Year)

30. Name and eddrass of person who completed cause of deeth (Itam 23a) (Type, Print)

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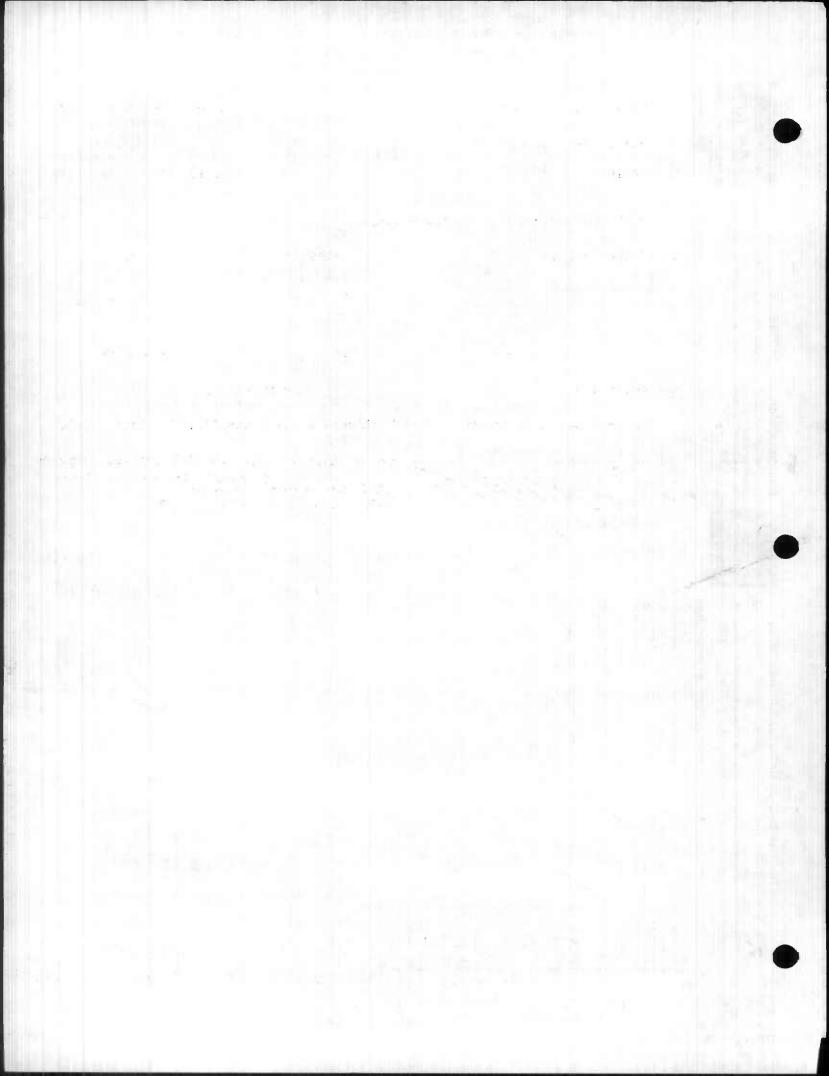
State Registrar

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31. Dete filed (Month, Day, Year) DEC 2 1 2000 21

6 Could not be

32. Registrar's Signetura



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nema (First, Middle, Last) 3. Time of Death 2. Data of Death Month Dev Year **Physician** Jafari Ghodratollah 12, 2000 December 3:05am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6540 Farmingdell Ct. Rockville Montgomery If Under 1 Year If Undar 24 Hrs.
Months Devs Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** Deys MM 20 F 421-60-7730 69 Director Aug 30, 1931 Tran Usuel Rasidence of Decedent the Meryland 10a State 10b County 10c. City. Town or Location 10d. inside City Limits r is marked other than "natural", or flems 23s or 28s-f show trsumstic avant, the Medical Examiner must be notified at 1☐ Yes 2√ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 6540 Farmingdell Ct. 20855 Funeral United States 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indien, 11. Maritel Status Bleck, White, etc. 1X Never Merried 2 Merried 1 Yes 2 No Specify: Maryland 21215-0036 Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda com filed within el Hygiene. Etamantary/Secondary (0-12) Coltega (1-4or 5+) Iranian Embassy 5+ Press Informant 18. Mothar's Name (First, Middle, Maiden Sumeme) 17. Fathar's Nema (First, Middla, Last) h and Mentel h should be Hossain Jafari Hajar (There is no last name) 19e. Informant's Neme/Relationship (Type, Pnnt) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Pages 1 and 2 s ment of Heelth an ant: If itam 27 is Mike Rush/ friend 12000 Cheyenne Rd. Gaithersburg, MD 20878 other Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) December Silver Spring, MD 6 permit. Page Department of Important: If any Injury Gate of Heaven Cemetery 22. Neme end Address of Fecility Rapp Funeral& Cremation Service 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. MD 20910 Approximeta Intarval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Physician/Medical Examiner deeth certificate be executed Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last the attending physician and the for use as the burial-tren Due to (or es e consequence of): Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert it. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert t. P.O. be detached that the signed by 1 Yes 2⊠No 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed been a Wel pege 2 certificate hes The 28 No 1 ☐ Yes 1 Yes 2 No of Vital Physician: 25. Wes case rafarred to medical examiner? Be 26. Piaca of Death (Check only ona) asi or Attan.

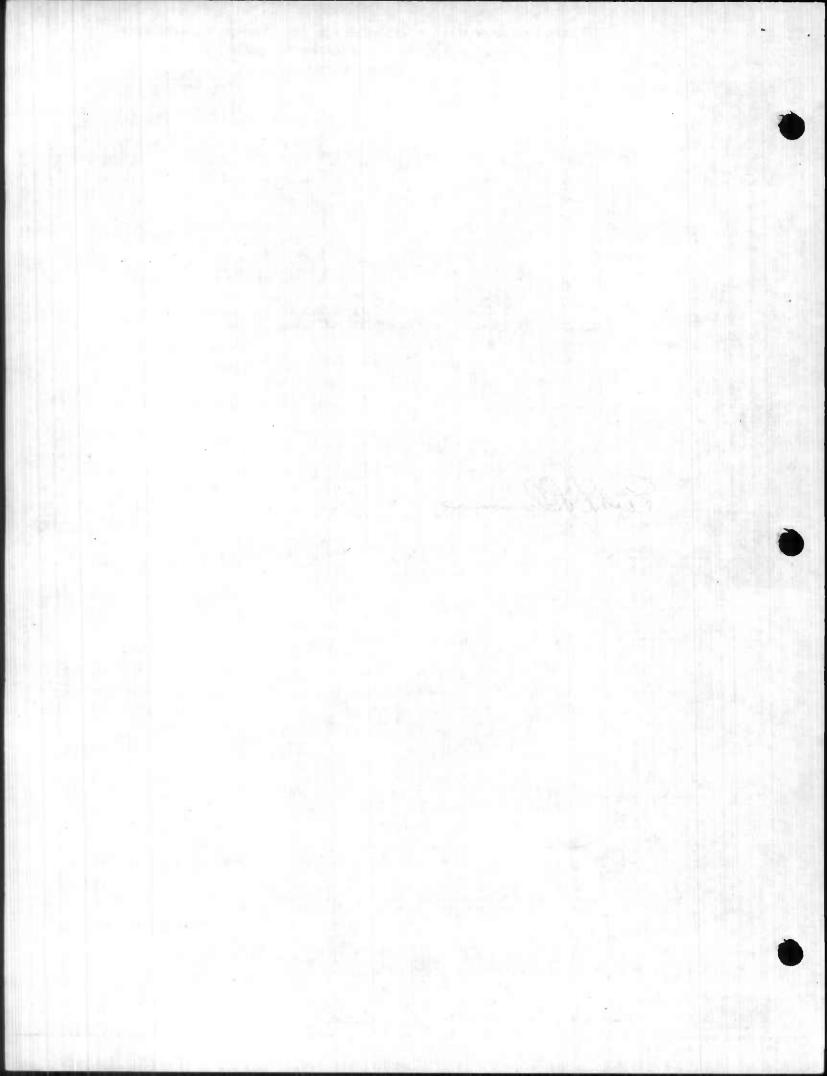
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Areai Director: After this ce Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No edical Certification: To 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Menper of Deeth 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar 29d. Dete signed (Month, Day, Year) 29b. Signeture end title-of certifier bom 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Deta filed (Month, Dey, Yeer) 32 Registrar's Signatura State 19 2000 DEC Registrar

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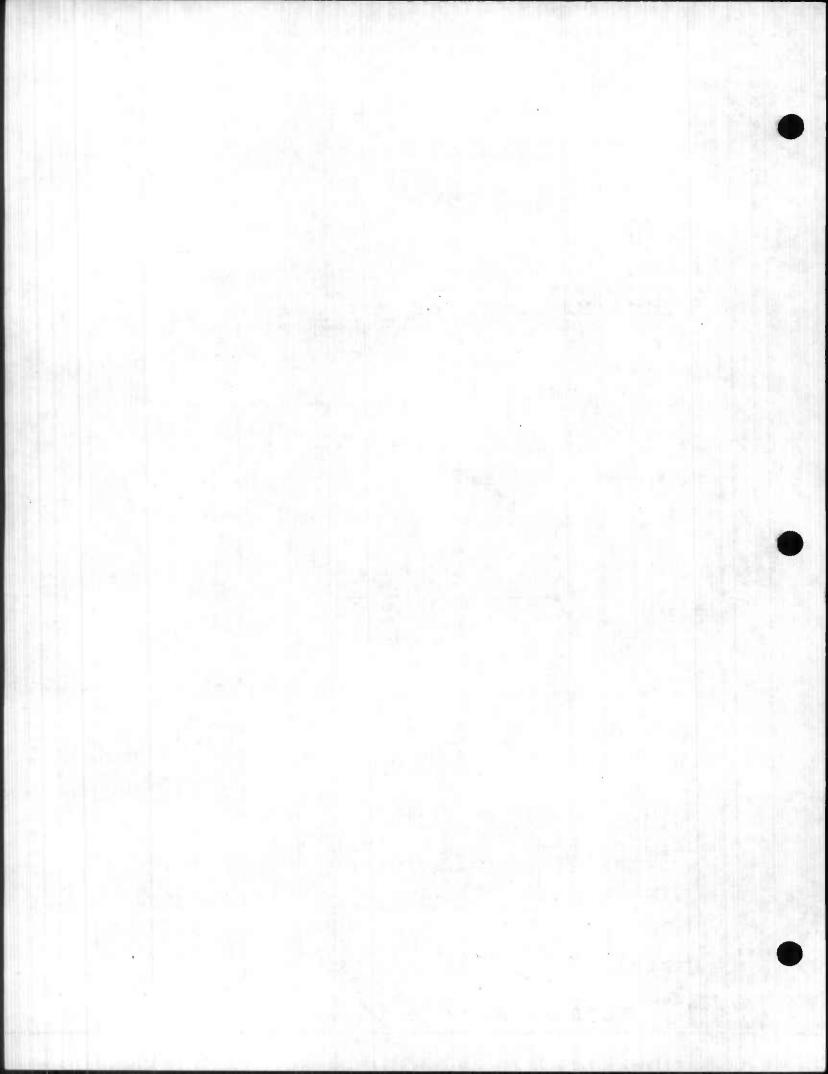
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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

									Ce	ertificate	of Dear	th		Reg. No.	1	211	36
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		Examine	6.	4a Facility Name (If r	n <i>ot institution, g</i>	rive stree	et end number	r)			4b. City,	Town, or Lo	cation of Death	4c. County	of Death		
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		or 28a-f	Director	10e. Street and Numi		iery		Dei	chesua	10f. Zip Co	ode			10g. Citizen of	What Coun	try?	
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	902	ral.	d by	3 🖾 Widowed 4	Divorced		Year or Dates	WWII		10 169 24	g NO Spec	my.	541	Specif	Whi	te	
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6	altimore,	artme ortan Injur		21. Signature of Fund				ALI		22. Name and			y 2001	Arling	LOII,	VA	
	Ba	permit. Peges 1 and 2 Department of Health a Important: if item 27 is any injury or other trau pnce.		b / lu	0100.	1	10		F	rancis	J. Col	lins		Home,			
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	o,	an er uriel-t	EX	Sequentially list conditions, leading to implementations. Enter Under Cause (Disaase or in	nadiate lying		Alzh	Dim	en)a	dist	0.80	9-33			i	UP.	ans
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	0	the a	ysic	Part II. Other signific	ant conditions	contrib	iting to death	but not res	sulting in the	undarlying cau	se given in Pa	art I.	23b. Did	tobacco use co	ontributa to	the caus	sa of death?
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Kat			edical Certification:	(Check only 2 one)	Medical Ex	aminer:	On the basis and manner s		ation and/or	invastigation, Ir	my opinion,	daath occurr	ed at the tima,	data and place,	and dua to	tha caus	10(s)
		withi To the	Ž	29b. Signature and fi	itla of certifiar	1 -	7	0.	1100	29c. l	icense numb			29d. Dafe sign	ed (Month,	Day, Yea	r)
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				Patricia 1	L. Tome	5KO	MD, 11	140	KOCKU	HILE Y'	Ke, PI	MB 31	18, Koc	kville,	MD	20	852
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DHMH 16 Rev 6/95

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December Mode Lease Compared Compa						Ce	rtificate	e of	Death	Re	g. No.	lamb	2161
Examiner Examin	Dhualain		1. Decedent's Name (First, Middle,	Last)	- PIL					2. Dete of Deet	h	Vaar	3. Time of Dec
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Second		-	4e. Fecility Name (If not institution,	give street end nu	ım <i>ber</i>)				4b. City, Town, or	Location of Deeth	1		
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23. Part I. Einer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate shock, or heart failure. List only one cause on each line.	permit. Depertrimports any ing		Lowett Sist	colke	A	Br	cadsha	w 8	Sons Fu	neral Hon	ne		
Physician (Medical Examiner) The properties of		+		-								2181	
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The standard of the standard o	the atterned for u	21018	Pert II. Other significant conditions	contributing to de	eath but not resul	lting In the u	nderlying ca	use gi	ven in Pert I.	23b. Did tol	acco use co	ntribute to	the cause of de
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The control of the	len: rtific stor,		25. Wes case referred to medical						26. Place of Dec	ath (Check only one)	1	
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29a. Certifler (Check only one) 29a. Certifler (Check only one) 29b. Signature end title of certifler 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Dey, Yeer) December 7, 2000 30. Nems end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Viiav Karumbunathan, M.D. – 201 Hall Highway – Crisfield, MD 21817	After fune		1 Naturel 5 ☐ Pending	28e. Dete (Mons	of Injury	28b. Time of	28	c. Inju Wo	ry et rk?				
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Vijav Karumbunathan, M.D 201 Hall Highway - Crisfield, MD 21817		-	30 Name and address of name ::	oomelated as	o of death fitter	7 (2a) (T	Deint'		1				
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Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Sarah Edith Kennedy December 13, 2000 06:30 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett **Goodwill Mennonite Home** Grantsviile If Under 1 Year | If Under 24 Hrs 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F Months Yrs 213-10-5251 87 Director 25-Jun-13 West Virginia Usuel Residence of Decedent the Menyland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Allegany Frostburg 10e. Street and Number 107 George Street 10f. Zip Code 10g. Citizen of What Country? "naturel", or items 23a or 21532-U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedent Ever in U.S. Armed Forcas? 14. Race - American Indian, 11 Meritel Status permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or item eny injury or other treumatic event, the Medical Emmin Black, Whita, etc. 1 Yas 2 No 1 Nevar Merriad 2 Married 1□ Yes 200No Baitimore, Maryland 21215-0020 Specify: Specifyite by 3 Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Homemaker 17. Fether's Neme (First, Middla, Last) 18 Mothar's Nama (First Middle Maiden Sumama) Be Albert Menear Victoria Molisee 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickie Unn Daughter 401 Grandview Drive Frostburg Maryland 21532-20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Crametion 3 ☐ Ramoval from State Frostburg Memorial Park 17-Dec-00 Frostburg, Maryland 4 □ Donation 5 □ Othar (Specify) 21. Signatura of Funaral Sarvice Licansee. 22 Nama and Addrass of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Paper. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition rasulting in death) /Medical 4 days Examiner Dua to (or as a consequence of): Examiner that the death certificate be executed ettending physicien end for use as the buriel-tren Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Diseese or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE Lung DISPASE Division of Vitai Records. P 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Demen TIA 2 No 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: 24 hours after deeth. Funeral Director: After this certifics 25. Was case refarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpetient 3 DOA funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) à 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Medicai 29e. Cartifiar 15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signatura and titla of certifian 29c. Licensa number 29d. Data signed (Month, Day, Year) 25638 2000 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)
S. T. Chang, M.D., 10701 New George Creek, S.W, Suite 3, Frostburg, Maryland 21532 M 31. Data filed (Month, Day, Xeer) DEC I 5 2000 82. Registrer's Signatur State sorks Registrar

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Duril Funeral Home, 57 host Ave., Fredbing, MC [12]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BARBARA EGNER LUKE 7:00 pm December 19, 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Bethesda
If Under 1 Year | If Under 24 Hrs. | 8.1 Suburban Hospital Montgomery 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 2 X F Days Hours Yrs. Director 58 January 26, 1942 142-34-6684 New Jersey Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Directo Maryland Bethesda Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 238 5224 Pookshill Road Funeral 20814 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Merital Status 1 Never Merried 2 Merried ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 5+ Marriage & Family Therapist Consulting 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be ment of Health and Mental ant: If Item 27 is marked o Gregory James Egner Anne Mayer 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert A. Luke, Jr./ Husband 5224 Pooks Hill Road Bethesda, Maryland 20814 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from Stete December 22, 2000 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signature of Funerel Service Licensee

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest,

Approximate

Approximate Interval Between Onset end Death Physician . METATATIC NON Somme LECT long (ARC: 20 mg Immediete Ceuse (Final disease or condition resulting in deeth) /Medical **Examiner** Due to (or as a consequence of): Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2E No 1 🗆 Yes

Be Completed page Medical Certification: To

or Attending I after death. after death.

P.O. Vital Records, Division

0-15

2 COSTOR

State Registrar

31. Date filed (Month, Day, Year) DEC 2 2 2000

25. Was case referred to medical

5 Pending

Investigation

6 Could not be

1 Yes 2 No

Manner of Death

Natural

2 Accident

3 Suicide

29b. Signature and

29a. Certifier

4 Homicide

29c. License number 075 675

28c. Injury at Work?

1 Yes 2 No

26. Piece of Deeth (Check only one)

Dr. OLNEY.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Sertifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner steted. 29d. Date signed (Month, Dev. Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) KALAN, Joseph

18111 32. Registrer's Signature

Hospital: 2 ER/Outpatient 3 DOA

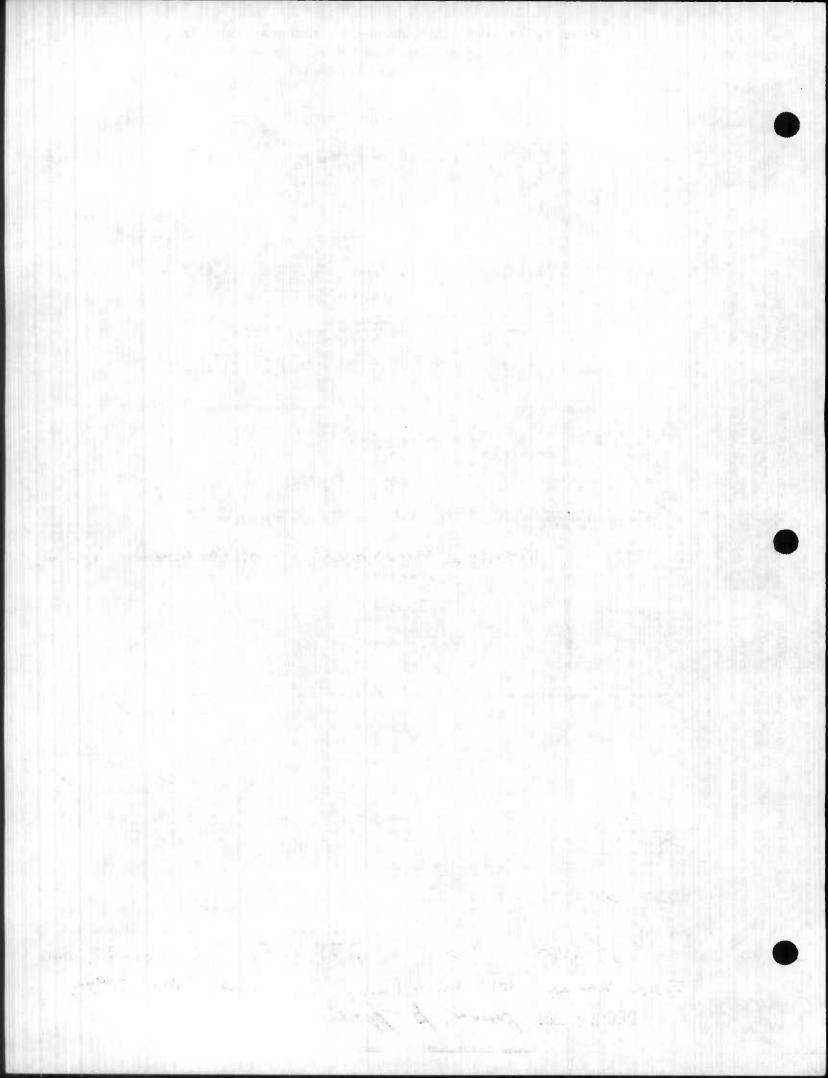
28b. Time of

Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

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To the Hospital within 24 hours a To the Funeral C

10



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** Trac - Nhien Lu December 14, 2000 7:40 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Daath 4c. County of Death Examiner Rockville Montgomery Shady Grove Nursing Home If Undar 24 Hrs. If Undar 1 Yaar 8. Data of Birth (Month, Day, Yaar)
Nov. 26, 1907 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Months Days Hours China 1⊠M 2□ F Yrs. 93 Nov. 580-18-2351 Director Usual Rasidanca of Decedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Madical Example must be needing an enes. 10d. Insida City Limits 1 ☐ Yas ZX No Directo Maryland Prince Georges Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7847 Jacobs Drive 20770 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 Never Married 2 Married Maryland 21215-0036 1 Yas 2 No Specify: Specify: Asian ğ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Be Tin-Po Lu Ching-Ying Luk 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 7847 Jacobs Drive, Greenbelt, Maryland 20770 Lap-Chi Lu / Son Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☑ Buriat 2 ☐ Cramation 3 ☐ Ramovat from State Gate of Heaven Cemetery 12/26/00 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Hines-Rinaldi Funeral Home 21. Signatura of Funeral Barvice Licensas 11800 New Hampshire Avenue Silver Spring, Maryland 23a. Party Entar the disease or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lynniy one cause on each line. Approximata tntarvat Between Onsat and Death Physician Immediata Causa (Final disaasa or condition resulting in death) /Medical 2 years Colon Cancer Examiner Dua to (or as a consaquance of): Examine The law requires that the death certificate be executed attanding physician and for use as the bunal-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasuiting in death) Last Dua to (or as a consequence of): P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Ware autopsy tindings available prior to completion of cause of death? been signature 24a. Wes en eutopsy performed? Completed certificata has b lirector, paga 2 s 1 Yas 2 No 1 ☐ Yas 2 ☑ No Physician: 25. Was casa raferred to medical director Be 26. Placa of Daath (Chack only ona) Hospitat: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4₺ Nursing Home 5 ☐ Rasidanca 6 ☐ Other (Specify) 1 Yas 2 No 2 this 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After Hospital or Attending 5 Pending invastigation 1 X Netural 1 Yas 2 No death. filled in by the f 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) aftar 4 Homicide To the Hospital of within 24 hours a To the Funeral Completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifian and mannar stated. 29d. Data signad (Month, Day, Year) 29c. Licansa number 29b. Signatura and titta of cartifiar My we. D52457 December 18, 2000 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

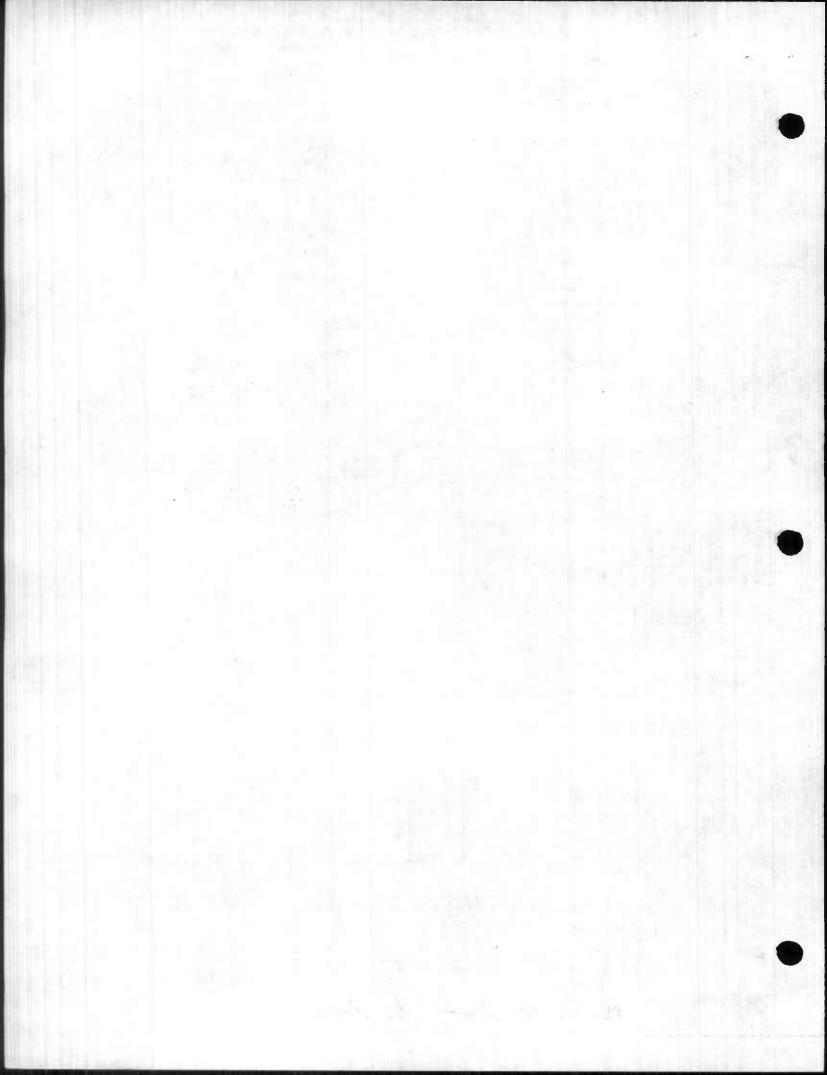
State Registrar

Mo-Ping Chow, M.D. 31. Data filed (Month, Day, Year) 2 1 2000 DEC

32. Registrar's Signatura

oaks

9001 Shady Grove Court, Gaithersburg, Maryland

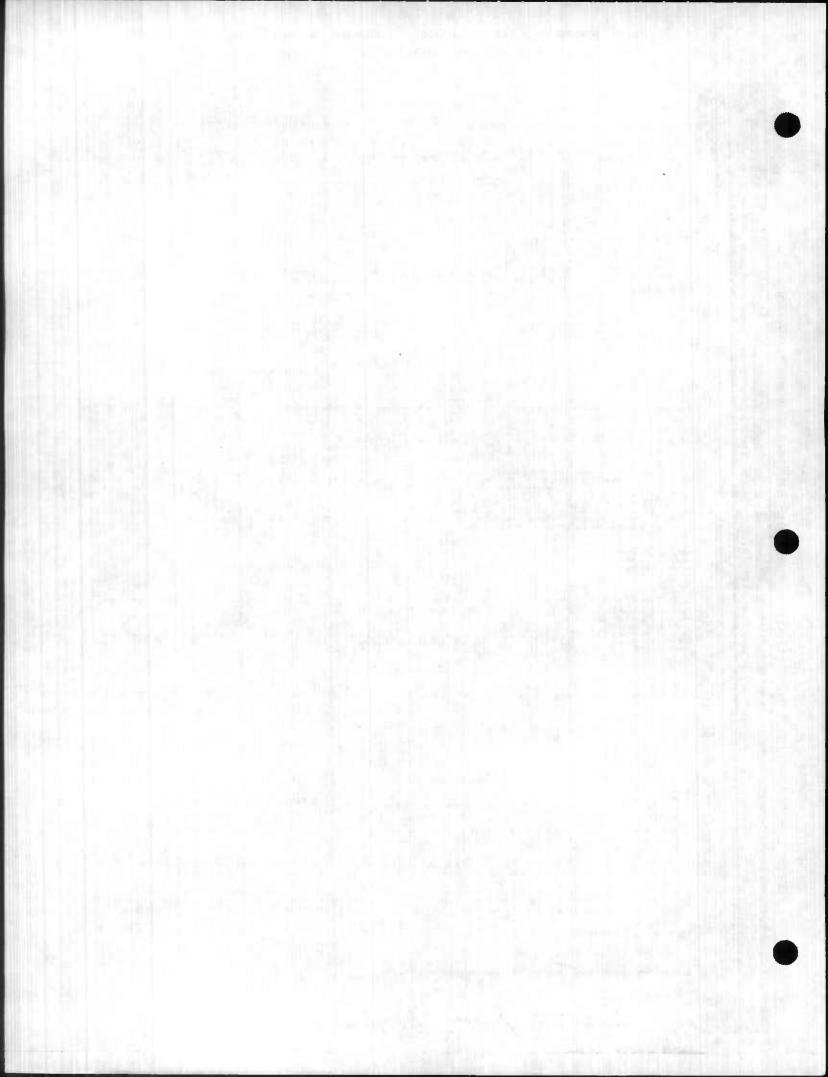


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State of Maryland / Department of Health and Mental Hygiene 1 1, 2 1

			Ce	rtificate d	of Death		Reg. No.	"Y Las	
115.1-	1. Decedent's Name (First, Middle, Last)		D/2012			2. Dete of De Month	eth Day	Year	3. Time of Deat
hysician /Medical	Geraldine Helen Lo	oginov Loef	ffler			Decemb	er 20, 2	2000	10:15 P
aminer	4a Facility Name (# not institution, give s	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death	
	Suburban Hospital				Bethesda		Montg	gomer	у
I	5. Social Security Number 6. Sex 119-32-3877	7. Age (h	58 Yrs.	If Under 1 Ye Months Da	eer If Under 24 Hrs lys Hours Min		th 19, Year) 1942	9. Birthp Court Nev	place (State or For htry) W York
	Usual Residence of Decedent 10a, State 10b, County	Lac	Other Town and						0.4 1
٥	10a. State 10b. County Maryland Montgomer		Chevy Ch					1	1 ☐ Yes 2 ☑
90	10e. Street and Number	- 7		10f. Zip Cod	la .		10g. Citizen of \	What Cour	ntry?
JO JE	4450 S. Park Avenu	ie, #1002		208			United		
by Funeral Director	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	or in U,S. 13.	Was Decedent If Yes, specify C	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	Specify Yes or No to Rican, etc.)	14. Rac Blac Specify	ck, White,	
Led L	15. Decedent's Educ	cation	16a. Dece	edent's Usual Oc	cupation	S	16b. Kind of B		
ple	(Specify only highest grade	College (1-4or 5+)	(Give	e kind of work do DO NOT use re	one during most of wa stired)	rking			
100	-	5+	Att	orney				Law	
To Be Completed	17. Father's Name (First, Middle, Last)					me (First, Middle,		10)	
To	Armand G. Ely				Gertrude	e Sheeh	an		
	19a. Informent's Name/Relationship (Typ.	pe, Print)	19b. Meil	ing Address (Str	reet and Number or A	ural Route Numb	er, City or Town,	Stete, Zip	Code)
	William A. Loginov/				rive, Lone	donderry			
	20a. Method of Disposition 1	emoval from State	Montgomery	Crematory or other	rium, Inc.	Dec. 22, 2000	20c. Location -	a, Ma	aryland
	23a. Part Enter the disease, or complication of the complete and the complete complete the complete co	tut M	0689 Be	thesda- Bethe	dress of FacilityRole Chevy Chases as Mary dying, such es cardia	se, Inc. land 208	7557 W: 14-3501	Iscon	eral Hom sin Aven Approximate Intervel Between
	Immediate Cause (Finel disease or condition	Sepsis						0	Onset and Death
edical Examiner	resulting in death) e	-	e to (or as a conse	equence of):		7000	128 118	1	ME WEEK
Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e to (or as e conse						
Physician/M	Part II. Other significant conditions cont		ot resulting in the	underlying ceuse	a civen in Part I	23b. Did	tobacco usa co	ntribute t	o the causs of de
Phys	Encephalopathy					10	Y88 2□ No	3₺ Pro	bably 4 Unk
Completed by	Cirrhosis of Live	er					an eutopsy omed?	ev co	ere eutopsy finding allable prior to empletion of ceuse death?
E						10	Yes 21 No	1[Yes 2 No
Bec	25. Was case referred to medicel				26. Piace of De	ath (Check only	one)		
ToB	examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ER/Outpatie	ent 3 DOA	Other:	Home 5 ☐ Resi		er (Specia	fy)
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Day Yo	ear) 28b. Time (Injury		njury at Work? 1 Yes 2 No	28d. Describe	how injury occur	red	
edical Certification:	3 Suicide 6 Could not be determined	28e. Place of tnjury building, etc. (5	- At home, farm, s Specify)	treet, factory, off	ice	28f. Location (City or To	Street and Numi wn, Stete)	er or Rura	al Route Number,
dical (ician: To the best of mer: On the basis of example and manner steted	amination and/or Ir						
Z	29b. Signature and title of certifier			29c. Lic	ense number		29d. Dete signe	d (Month,	Day, Year)
	1 flue!				609		Decembe	er 20	, 2000
	30. Name and eddress of person who cor						0070		
	Raman R. Tuli, M.D.	. 10810 Da	rnestown	Road, C	Saithersbu	rg, MD 2	0878		
State gistrar	31. Dete filed (Month, Day, Year) DEC 2 2 200	32. Registrer's		hoose	Kal				

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State of Maryland / Department of Health and Mental Hygiene 13 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Dey 2000 DEC. **Physician** LEVINE 21, JOSEPH 9:00A. /Medical 4b. City, Town, or Location of Deeth 4e Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner Rockville Revitts House -6111 Montrose Road Montgomery If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
Aug. 3, 1911 if Under 1 Year 9. Birthplaca (Stata or Foraign 7. Age (In yrs. last birthday) **Funeral** Days Hours 15 M 2□ F Months New York 89 133-03-4132 Director Usual Residence of Decedent 10c. Çity, Town or Location 10e. Stete 10b. County 10d. tnside City Limits 25a-f show must be notified at Rockville Maryland Montgomery 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? ð 20852 United States 6111 Montrose Road "natural", or harns 23a Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Tyes 2 No
If Yes, Give
Year or Dates: WWII 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White p 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Stock Clerk Government 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middla, Last) 88 h and Mental ! should be Sophie Levine Balkin Samuel 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Nem 27 Is n Marcia Akresh - Daughter 9209 Gatewater Terrace Potomac, Maryland 20854 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 \$\frac{1}{2}\$ Buriel 2 □ Cremetion 3 □ Removel from Stete 4 □ Donation 5 □ Other (Specify) 8 Wellwood Cemetery 12/22/2000 Long Island, New York 22. Name end Address of Fecility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 1. Entagged disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, to the disease of the death. Approximete interval Between Onset end Death Part 1 **Physician** immediete Cause (Finel diseese or condition resulting in death) /Medical 5 years Renal Carcinoma Examiner Due to (or es a consequenca of): Examine attending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Box 68760 Physician/Medicai Dua to (or es a consequença of): signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, by 24a. Was an eutopsy performed? 24b. Were eutopsy findings available prior to Completed peen s completion of cause of deeth? has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Physician: Be 25. Was case referred to medicat 26. Placa of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? edical Certification: 5 Pending investigation tnjury 1 ONaturel 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) 28a. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeloten: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 10 2000 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) Henry Roth, M.D. 1801 East Jefferson Street Rockville, Maryland 20852

DHMH 16 Rev 6/95

State

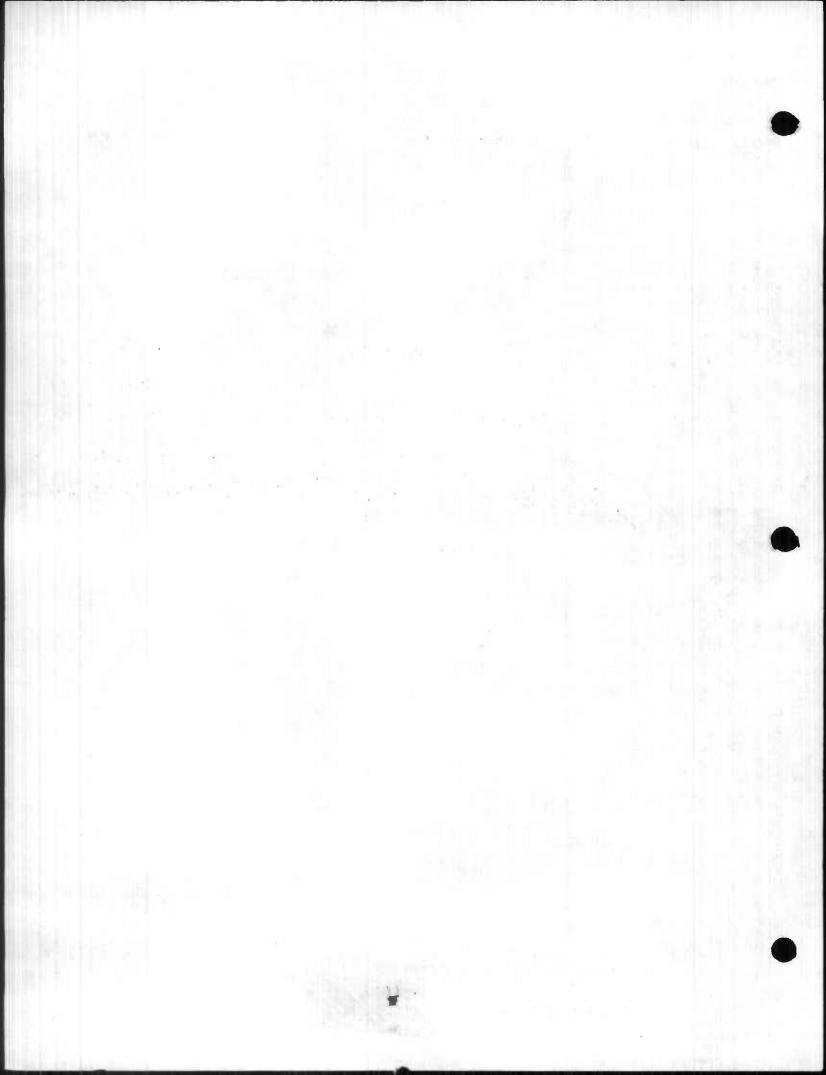
Registrar

31. Data filed (Month, Dey, Year)

DEC 2 2 2000

32. Registrar's Signeture

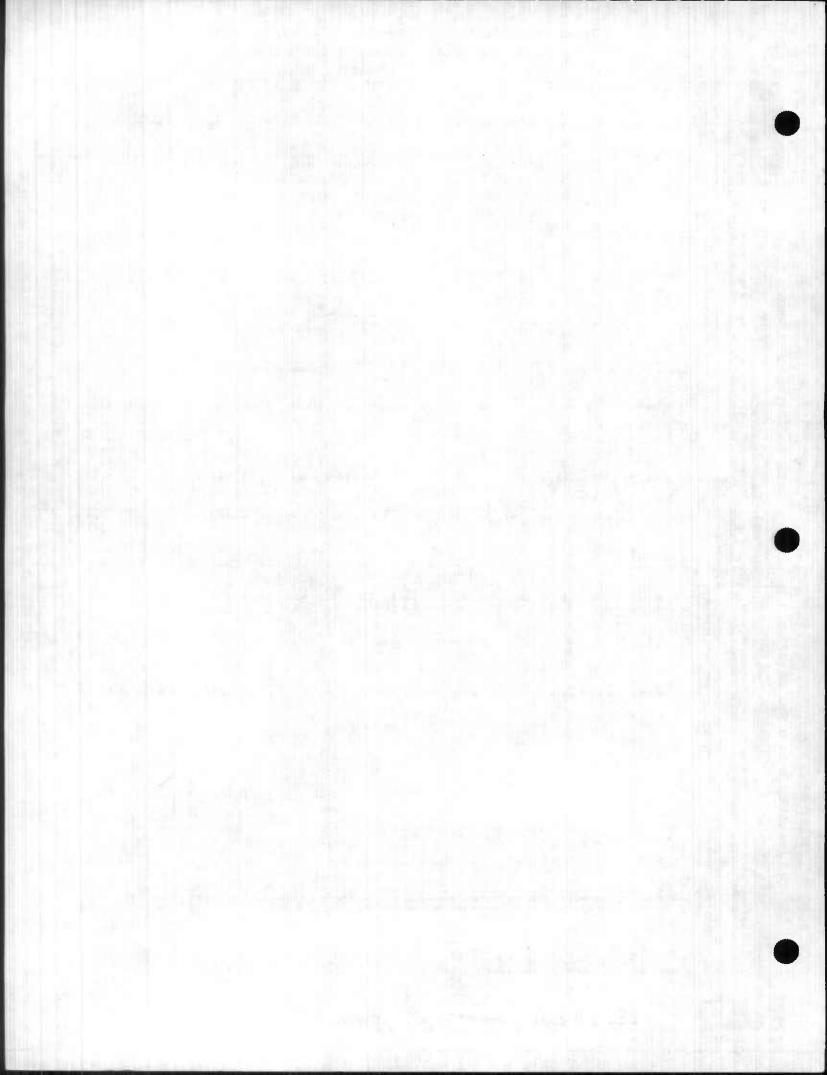
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/Med		Bernice B. L	evin					E61633	Decemb				4:30	MAC
Exam		4e Facility Neme (If not institu	tion, give street end nu	m <i>ber</i>)			4	b. City, Town, or L	ocation of Deat	h 4c.	County	of Death		
34-		Sycamore Ac	res					Derwood		M	ontg	omery		
Funera	1	5. Social Security Number	6. Sex 1 □ M 20XF	7. Age (In yrs	. last birthday)	If Under 1	Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	th ey, Year)				or Foreign
Directo	r 📒	479-22-5932	10 M 2014	84	Yrs.				Nov. 6			New		
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seift with the Maryland ns 23e or 28e-f show must be notified at	-	10e. Street end Number				10f. Zip Ci				10g. Cit	izen of v	Vhet Countr	ry r	
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ar de Neme	e e	11. Meritel Status	Armed Fo		U,S. 13.	Wes Deceder If Yes, specify	t of H Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.))-		e - America k, White, e		
	by F	1 Never Merried 2 N 3 Never Merried 2 N 3 Never Merried 2 N	If Yes, Gi	ve		1□ Yes 2X] No	Specify:			Specify			
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Geath certificate be aw death certificate be aw e attending physician a d for use as the burial	Physician/Medical	thet initieted events resulting in death) Lest	d	Due to (or as a conseq	uence of):						i t		
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O & # 4	ysi	Pert II. Other significant cond	itions contributing to d	eath but not re	suiting in the u	nderlying cau	se giv	en in Perti.		Yes 2		3 Prob		Unknow
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of Vital Physician: The this certificate ral director, pag	o Be	25. Wes case referred to med examiner?	Hospital:				Oth	26. Place of Dee						
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or Attendent from the death	Certification:	3 Suicide 6 Cou	ordinated 28e. Plece build	of Injury - At I	home, farm, str ify)			103 2	28f. Location City or To			er or Rurel	Route Nu	m <i>ber</i> ,
Hospita 4 hours Funeral taly fille	edical C		ying Physician: To the al Examiner: On the b end men											(s)
To the To the Comple	Me	29b. Signature and title of cert	1 /			29c. L	icens	e number		29d. Da	ite signe	d (Month, D	Dey, Year)	TEN
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day **Physician** Month Anne C. Lee December 19, 2000 3:20 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Hours Months Days 1 □ M 2 1 F 579-46-7295 Yrs 65 Sep. Director 16, 1935 Washington, DC Usual Rasidence of Decedant with the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Director 1 ☐ Yas 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Brantford Avenue 20904 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Raca - Amarican Indian, Black, Whifa, atc. pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "naturel", or the eny injury or other traumatic event, me test at Examina and 1 ☐ Yas 2 ☒ No If Yes, Giva 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White PV 3 Widowed 4 □ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Lawyer Dept. of Navy 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Be William B.Cunningham Gertrude Hunter 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 13771 Palmetto Circle, Germantown, Maryland Diana Ludington / Daughter 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Gate of Heaven Cemetery 12/22/00 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Hines-Rinaldi Funeral Home 21. Signature of Funaral Sarvice Licensee 11800 New Hampshire Avenue alan bonuell Silver Spring, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Between Onsat and Daath **Physician** /Medical Immediata Causa (Final Cardiac arrest 30 minutes disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner Coronary artery disease burial-transit requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseese or injury that initiated evants rasulting in death) Last and Dua to (or as a consequenca of): physician s the burial Box 68760 Physician/Medical Dua to (or as a consequence of): 60 for use as the hed P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by the 3 Probably 4 Unknown 1 Yes 2₺ No Records. by 24b. Wara autopsy findings availabla prior fo complation of causa of daath? Be Completed 24a. Was an autopsy page 2 1 Yas 2 No 1 ☐ Yas 2 ☑ No certificate of Vital Physician: director. 25. Was casa rafarred to medical 26. Placa of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA this Option of Africa funeral 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be dataminad 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide n 24 hou. Hospital 150 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Funs completely fi 29b. Signatura and fitla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 100 21 D00143 December 19, 2000 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) 8630 Fenton Street, #230, Silver Spring, Maryland Hubert Alpert, M.D.

DHMH 16 Rev 6/95

State

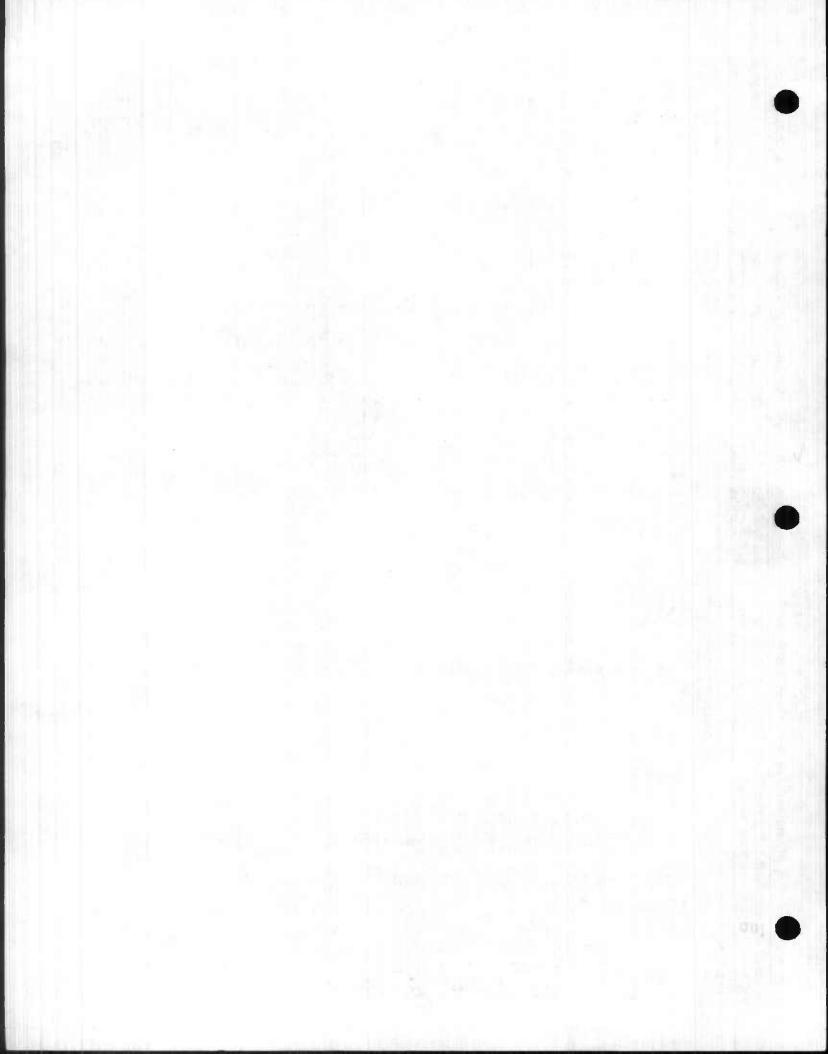
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31. Data filed (Month, Day, Year)

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32. Pegistrar's Signatura

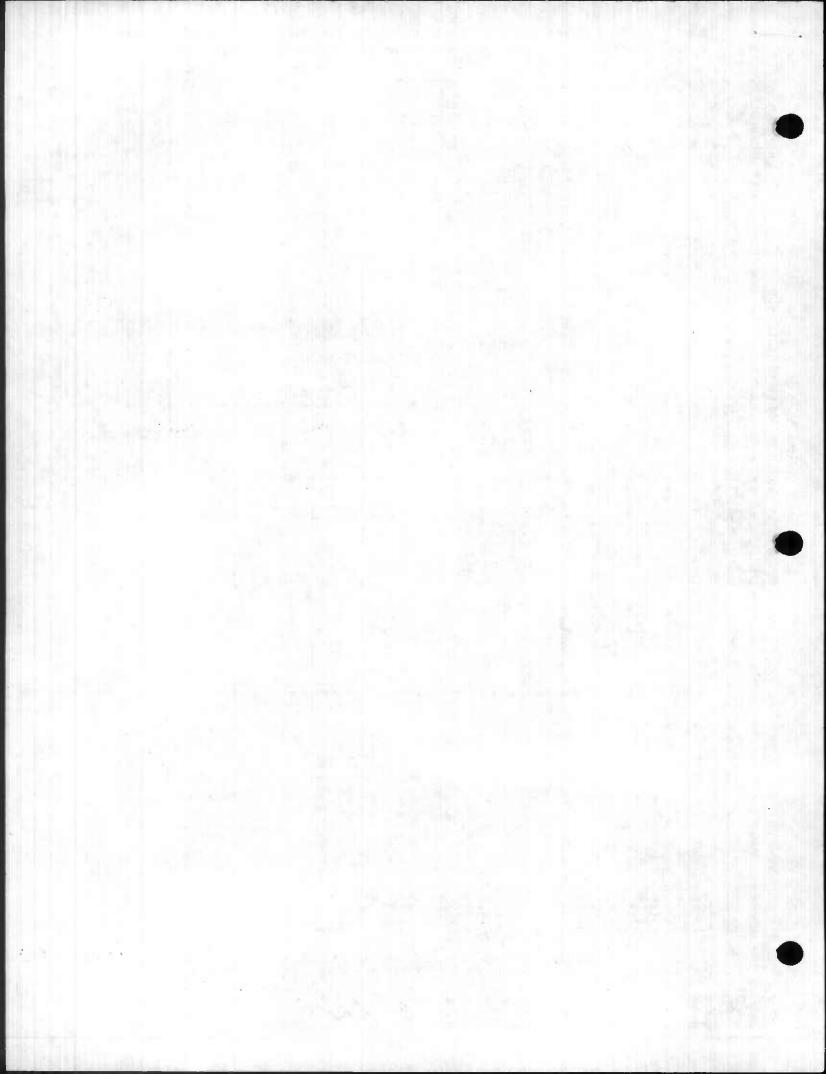
Deneral



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #5.12/26/2000, BMW, Montg. Co. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Yesi **Physician** Mary Strickler LaRue 7:10 pm December 20, 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Adelphi Prince George's 1914 Merrimac Drive 5. Social Security Number 2220 - 18 - 8994 8. Date of Birth (Month, Day, Year) Months Days Hours Min 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 2 F Months Yrs 87 Aug 21, 1913 Director Maryland Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location x 28a-f show 10d Inside City Limits 1 ☐ Yes 2 No Directo Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 0 2 with filed within 72 hours after death withygiana.
Whysiana. ** naturel*, or frems 23a ent, or Medical Examinar rolls. 1914 Merrimac Drive 20783 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Detes: 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indien. Black, Whita, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 XNo Specify. Specify: White P 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) English Teacher Gallaudet University 5+ 7 is marked other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pagas 1 and 2 should be nant of Haalth and Mental Int: If Item 27 is marked or William Henry Strickler Anna Beier 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Denise H. LaRue/ Daughter 15904 Pinecroft Lane, Bowie, MD 20716 item 2 Baltimore, 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Important: If it any injury or c page. 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from Steta 4 ☐ Donetion 5 ☐ Other (Specify) Philos Cemetery 12/27/00 Westernport, MD 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Signeture of Funarel Sarvice Licensee do 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiretory arrest, shock, or heer teilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Cause (Final diseese or condition resulting in deeth) /Medical e. Atrial Fibrillation month Examiner Dua to (or es e consequence of) Physician/Medical Examiner physician and s the burial-transit certificata be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): Box 68760 thet initieted events resulting in deeth) Last Dua to (or as a consequence of): 88 attanding usa O P.O. I signed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Rhumatic Heart Disease Division of Vital Records. p 24b. Were autopsy findings 24a. Was an autopsy Completed completion of ceuse of deeth? cartificate has a 1 Yas 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes cese referred to medicel 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 \$\overline{\mathbb{N}}\$ Residence 6 Other (Specify) 1 XYas 2 No 10 this 27. Menner of Deeth 28a. Dete of fnjury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred Certification: After 1 Neturel 5 Pending Investigation Injury after death. Director: Af 1 Yes 2 No 2 Accident tha 6 Could not be determined 3 Suiclde 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 2 4 Homicide filled in A Hospital 29e. Certifier 1 💢 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completaly fi edicai (Check or one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signatur 29c. Licanse numbe 29d. Data signed (Month, Day, Year) 30. Nema and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Pamela Mulshine 11251 Lockwood Drive Silver Spring, MD 20901 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State DEC 22 2000 enero Registrar

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State of Maryland / Department of Health and Mental	Hygiene	1 4	21	71	4
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Physici /Medic	an							2. Date of Dee			Time of Deeth
/iviedic	-	MILDRED	L. LOVE	LESS				Month December	6, 200	OO G	9:00 A.M
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a-f show	ctor	10e. State 10b. County Maryland Worcest		c. City, Town	or Location OW Hill						nside City Limits
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within 72 ho lene. r than "natur the Med cal	Completed	15. Decedent's Edu (Specify only highest gred Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)			ork done ise retire	petion during most of w ed)	orking	16b. Kind of Bu		1
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/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in deeth)			APRE consequence of					1	HUIR
deem cermicate be executed e ettending physician and of for use es the buriel-transit	VMedical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest	c	to (or es e c	consequence of	;	AL FA	ILVRE		3	MONITH
eeth ce ettendii d for use	Clar	Pert II. Other eignificant conditions con	ntribution to don't but a		Abo condentation		tion to Plant	ook Dida		addition to the	cause of death?
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sw requir	Completed by	RECENT	GASTRO	ENTH	21713 6	DE	THORM	24a. Wes e perfor	n eutopsy med?	evailabl	utopsy findings le prior to tion of cause n?
pag								1□Y	es 2 No	1 ☐ Yes	s 2□ No
this certificate	m	25. Wes case referred to medical examiner?	Hospitel:			Ot		eath (Check only or			
Artending Priya	ation: To	1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigation	1 ☐ Inpatient 28e. Date of Injury (Month, Dey Ye		petient 3 C ime of njury	28c. Inju	4 (E) redising	Home 5 Reside			
or the nospital or stranding in within 24 hours effer death. To the Funeral Director: After completely filled in by the funeral or stranger.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, fer	m, street, fecto	y, office	Ci .	28f. Location (S City or Town	treet end Numb n, Stete)	er or Rural Rou	ite Number,
within 24 hours e	edical (29a. Certifier (Check only one) 1 Certifying Physical Examt	sician: To the best of moner: On the besis of exe end manner stated.	y knowledge, minetion end	death occurred for Investigetion	et the ti	ime, date end ple oplnion, deeth oc	ce, end due to the courred et the time, d	euse(s) end me ate end place,	enner es steted end due to the	ceuse(s)
Within To the	Chart	29b. Signature and title of pertifier			25	c. Licen	se number	2	9d. Date signe	d (Month, Dey,	Year)
71-0		30. Name and eddress of person who or	Xa Mass		Type Print\	L	0-0584	5	Decembe	er 6, 2	000
		Robert C. LaMar, 1				; - ;	Snow Hil	1, MD 21	863		

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State of Maryland / Department of Health	and Mental Hygiene 0 4217	
Certificate of Death	h Ben No	

						Ce	rtificate o	f Death			Reg. No.		
	Physician /Medical Examiner 1. Decedent's Neme (First, Middle, Last) WILLIAM GERALD LANKFORD 2. Dete of Deeth Month Dey Year Dey 12. 2000 23. Time of Death Month Dey Year 23. Of 24. County of Deeth PENINSULA REGIONAL MEDICAL CENTER 4b. City, Town, or Location of Deeth WICOMICO 4c. County of Deeth WICOMICO												
	•	_	WILL	IAM GER	RALD L	ANKFO	ORD						23 09
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			PENINSULA	REGIONAL	MEDICAL	CENTE	R	SAL	ISBUI	RY	MIC	OMIC	0
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200	Director	2	218-34-7845	1 ⊠ M 2□ F	63	Yrs.	Wichitia Dey	S Mours	191111.	October	24, 1937	Mai	rýland
	7 .	-	suel Residence of Decedent		140.00	-							
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	o Maria	9	-			1.10	al TOIL St	acton					
	or 28a-1		e. Street and Number 1671 Green Road	4			10f. Zip Code		,		10g. Citizen of W		try?
			1071 Green Road					21838)		U.S.		
	r der	Funeral	. Merital Status	Armed F	cedent Ever in U, orces?		Wes Decedent o	f Hispanic Or uban, Mexica	rigin? (Sp n, Puerto	ecify Yes or No Rican, etc.)		- Amedo k, White,	an Indian, etc.
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0020		d by	3 ☐ Widowed 4 ☑ Divorced		Dates:	War							
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a	Map of my le	2	1. Signature of Furierel Service	See della	. /		2. Name and Add cadshaw			eral H	ome		
			Robert H. Br	adshaw,	72		06 W. Ma					2181	
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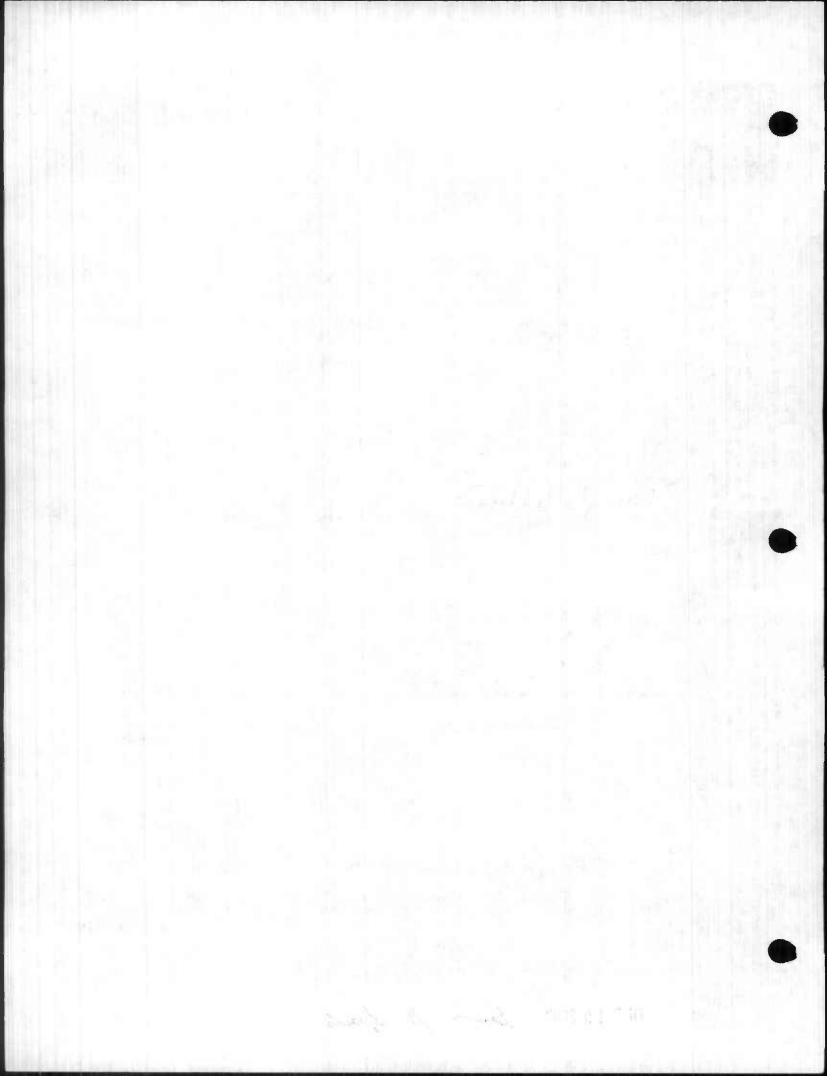
DHMH 16 Rev 6/95

DEC 1 5 2000 James G. Musely

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State of Maryland / Department of Health and Mental Hygiene 12178

Higher within 72 hours enter obean with the maryland Hydren and marker than 23a or 28a-f show and, the modes Examiner must be notified a Completed by Funeral Director	5	1. Decedent's Neme (First, Middle, Last HUGH WESTFALL 4e Facility Neme (If not institution, give SACRED HEART H 5. Social Security Number 6. S. 219-10-4627 Usuel Residence of Decedent 10a. Stete 10b. County MARYLAND ALLE 10e. Street and Number 12 WALKER ROAD	LIVENGOO street end number) OSPITAL ax AM 2 F	7 6	st birthdey) Yrs.	if Under 1		CUMB	D wn, or Loca ERLA	Dete of Deeth Month December Ition of Death	r 16,		
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or frame	Di rane	11. Meritel Status				10f. Zip C	21	502			USA	AALIGI COI	untry r
by by		1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes:	lo		Vas Deceder Yes, specify Yes 2		lispanic Orl en, Mexicar Specify:	gin? (Speci i, Puerto Ri	fy Yes or No- can, etc.)		ck, White	nican Indien, o, etc. WHITE
natur diesi		15. Decedent's Ed (Specify only highest gra	ucation de completed)		16e. Deced	ent's Usual (kind of work OO NOT use	Occup done	etion during mos	t of working		6b. Kind ot B	usiness/i	ndustry
ygiene. Northen "netun nt, me Medical Completed	5	Elementery/Secondary (0-12)	College (1-4or 5-	+)		AL M					TRANS	SPOR	TATION
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in it is	2	20e. Method ot Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif)		BL(ce of Dispos netery, crem OMIN	sition (Neme netary or oth IGRO	of er plea S E	CEME	C 20 TERY	,2000°	FRIEI	- City or 1	Town, Stete
Departin Importa any inju		Signeture of Funeral Service Licen	S Haler		22.	Neme end HAFEI	R C	CHAPE	L OF	THE H	HILLS	MOR MD	TUARY 21502
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hysician /Medical												1	Onset end Death
xaminer		Immediate Ceuse (Final disease or condition resulting in death)	6.			MY:	Cor	NA					YEAR SMONTH
ةِ الساء	5			Due to (or e	es a conseq	uence of):						l l	
in end iel-trensit Examiner	Yası	Sequentially list conditions,	b	Due to (or e	es e consequ	uence ot):							
ng physicia es the bur Medical	MICHIGAIN I	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest	c	Due to (or e	es e consequ	uence of):	ĺ						
d by the ettendireteched for use		Pert II. Other significant conditions or	ontributing to death bu	it not result	ing in the un	nderlying cau	use div	en in Part I		23b. Did to	bacco use co	ontributs	to the cause of death?
signed by the ettendid be deteched for used by the ettendid by the betterning by Physician/	L L						300 g.,				2 □ No		robably 4 Unknown
shoul	חפופת מ									24a. Wes e	n eutopsy ned?		Were eutopsy tindings eveilable prior to completion of cause of deeth?
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is certificate director, pag		25. Wes case reterred to medical examiner?						26. Plece	ot Deeth	Check only on	e)		
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within 24 hours eiter deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	Incari	2 Accident Investigation 3 Suicide 6 Could not be determined		iry - At hom	ne, ferm, stre	M eet, tectory,		Yes 2		8t. Location (St City or Town	reet end Num	ber or Ru	urel Route Number,
within a respiration of a trient within the Funeral Director: completely filled in by the Medical Certifica							A4 - 41-		d also as				atatad
within 24 hours To the Funeral completely fille			/sician: To the best o Iner: On the basis of end menner ste	examinetio									
	10	29b. Signeture end title of certifier	artygo	in An I		29c.	Dr.	se number	. /	2	9d. Date sign	ed (Monti	7
10	-	10 Name of 1 1 1	completed source at de	oth /Itom f	22a) /Time 1	Print)	VJ	47	<i>†</i>	De	ecember	: /5	, 2000
nes		30. Name and address of person who o		JR.	MD (Type, I	912.	Sin	N PRI	VE a	MIBITEL	M and	Da	1502
State Registrar		31. Dete filed (Month, Dey, Year) DFC 1 9 2000	32. Registre	r's Signetu	ire /	,					1		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Lueck Dorothy 23 December 2000 9:25 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Sacred Heart Hospital Cumberland 8. Date of Birth (Month, Day, Year) Sep 22, 1939 Birthplace (State or Foreign Country) If Under 24 Hrs. If Undar 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Days Hours 1□ M *□ F Months 215-36-8489 61 Usual Residence of Decedent 10d. Inside City Limits 10a Stata 10b. County 10c. City. Town or Location 1 Yas 2 □ No Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 11 Bane Street 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ᢓ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Helen (Ort) Cantrell Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Bane Street; LaVale MD 21502 19a. Informant's Name/Raletionship (Type, Print)
James T. Lueck 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 12/24 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Funeral Home2000 Cresaptown, MD Scarpeiri füheral Home, P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIAL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown losselar INFARCTION 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? D'ABETES Mell 2 200 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dopatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed After this certificate has septal or Attending Physician: Thours after death.
Ineral Director: After this certificat
y filled in by the funeral director, p Physician:

Physician

/Medical

Examiner

MD

Directo

Funeral

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Director

the Medical Examiner must be of

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permit. Pages 1 and 2 at Department of Health and Important: If hen 27 is n any injury or other traum 9008.

Physician

Examiner

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Physician/Medical Examiner

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Box 68760 Division of Vital Records.

Certification: To the Hospital of within 24 hours at To the Funeral D completely filled in edicai 3

State

obert Welk 31. Date filed (Month, Day, Year)

108012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seton 902 32. Registrar's Signature

Gener

oaks)

Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d, Date signed (Month, Day, Year)

December 23 2000

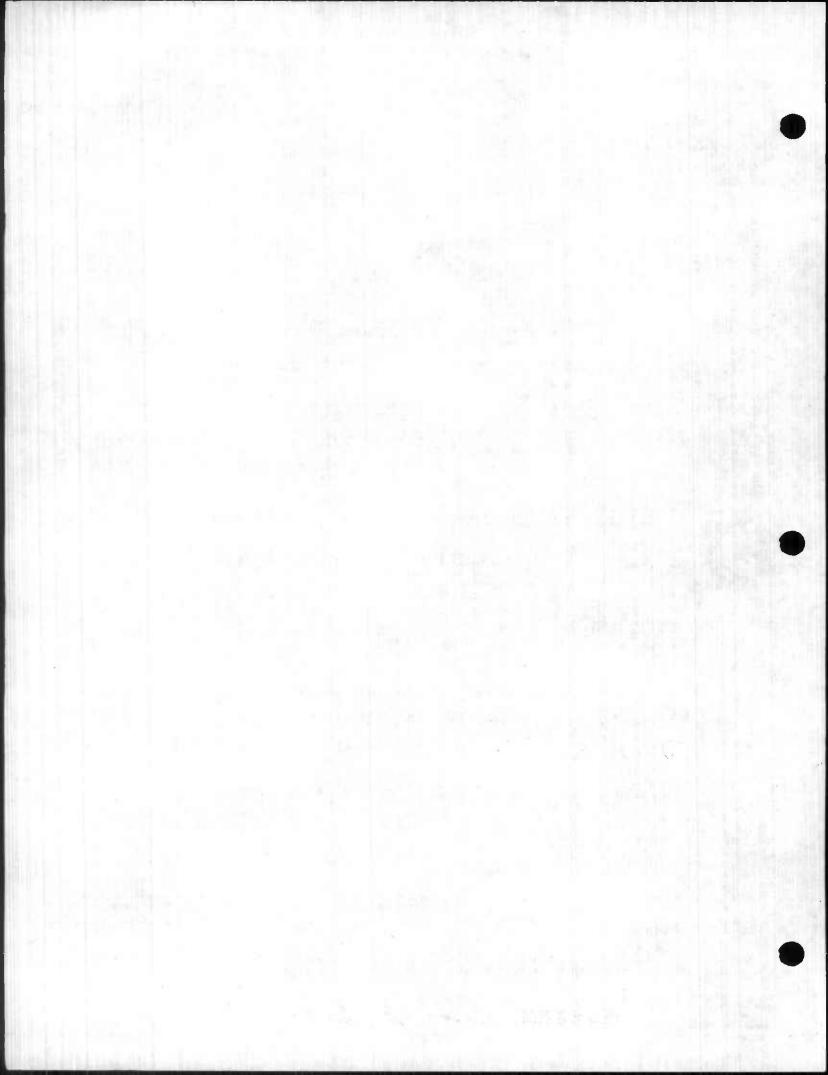
herland MD 21502

DEC 2 6 2000 Registrar

4 ☐ HomicIde

29b. Signature and title of certifier

29e. Certifier



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Tima of Daath Month Day Dec. Nora Isabella Monroe 20 2000 1:30PM 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Waldorf Healthcare Center Waldorf Charles If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Hours Days Months 1□M 2\ F 217-32-3225 June 29,1905 Maryland Usual Rasidenca of Decedent 10a Steta 10b County 10c. City, Town or Location 10d. Insida City Limits Charles Waldorf 1 ☐ Yas 2 No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 4140 Old Washington Road 20601 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - Amarican Indian, Black, Whita, atc 1 Yas 2 No If Yes, Giva Year or Datas: 1 Nevar Merried 2 Married 1 ☐ Yas 2 ☑ No Specify: White Specify. 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Clerk 6 Retail Drug Store 18. Mothar's Nama (First, Middle, Maidan Sumame) 17. Fether's Nama (First, Middle, Last) Ira Milstead Marion Adelaide Davis Milstead 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnformant's Name/Ralationship (Type, Print) John Monroe/Son P.O. Box 241 La Plata, MD. 20646 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stata Trinity Memorial Gardens 12/23/00 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 of Funeral Service Licenses 22. Nama end Addrass of Fecility AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part1. Entar the disease, or complications that caused the death. Do not entar shock, or heart failure. List only one cause on each line. 567 LA PLATA, MD. 20646 Approximeta Intarval Batween Onsat and Death Immediata Causa (Final diseasa or condition rasulting in daath) MONTH Sequentially list conditions, if any, leading to immediate causa. Enter Underlying

Physician /Medical Examine

attending physician end for use as the burial-transit

signed by the at the detached for

page 2

funeral

within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu

The lew requires that the death certificate be executed

Hospital or Attending Physician:

To the

Division of Vital Records. P.O. Box 68760.

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

MD

Funeral

Director

Examiner

Part II. Other significant conditions cor	ntributing to death but not res	sulting in the underlying	causa given in F	Part I.	23b. Did tobacco use co	ntribute to the cause of death?
					24a. Wes en eutopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
					1□ Yas 2000	1 □ Yas 2 □ No
25. Was casa referred to medical axaminar?			26. F	Placa of Deat	h (Check only one)	
1 Yas 2 No	lospital: 1 Inpatient 2 I	ER/Outpatient 3□ D	OA Other: 4	Nursing Ho	oma 5 Rasidence 6 Oth	ar (Specify)
27. Mannar of Death 1 Natural 5 Pending 2 Accident invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work? 1 ☐ Yas	2□No	28d. Dascribe how injury occur	red
3 Suicida 6 Could not be detarmined	28e. Place of Injury - At h building, etc. (Special	oma, farm, street, factor	y, office		28f. Location (Street and Numb City or Town, State)	per or Rural Routa Number,

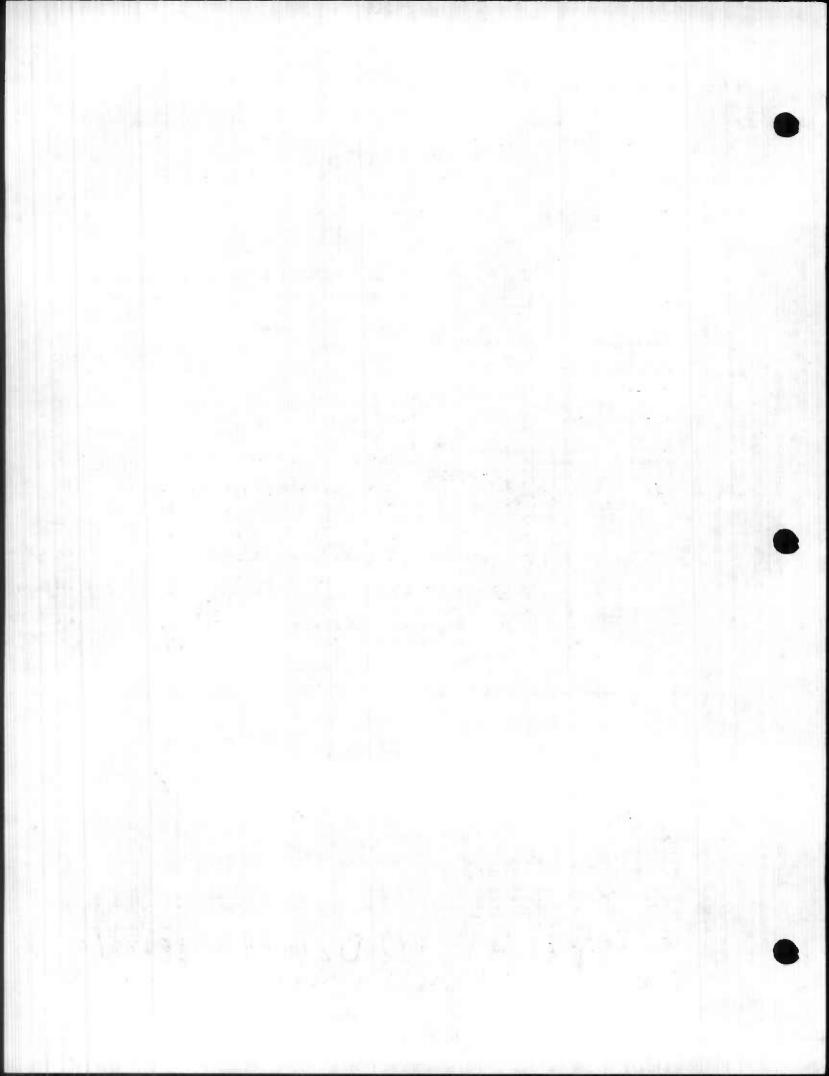
State Registrar

31. Dete filed (Month, Day, Year)

32. Registrar's Signatura DEC 2 2 2000

who completed causa of death (Item 23a) (Type, Print)

orr, md



Box 68760, Division of Vital Records, P.O.

the attanding physician and hed for use as the bunal-transit requires that the death certificate be executed 6 2 peed aw page 2 certificate has The or Attending Physician: After this funeral within 24 hours after death.
To the Funeral Director: After completely filled in by the fun To the Hospital

Physician

/Medical

Examiner

Director

Funeral

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Experience mark be notified at

filed within 72 hours after Hyglene.

permit. Pages 1 and 2 should be file Department of Health and Mentai Hy Important: If them 27 is marked oth any Injury or other traumatic event RDEs.

Physician

/Medical

Examiner

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Physician/Medical

by

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Maryland 21215-0036

Baltimore,

the Maryland

with

death

Certification: 29a. Certifier edical

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. 29b. Signature and title of certifier Brys

29c. License number
D 28656

29d. Date aigned (Month, Day, Year)

30. Name and strilless of person who completed cause of death (Item 23a) (Type, Print)
RAYI VACCI MD 15225 SHADY GROVE ROAD #208 ROCKVILLE MD 20850 MD

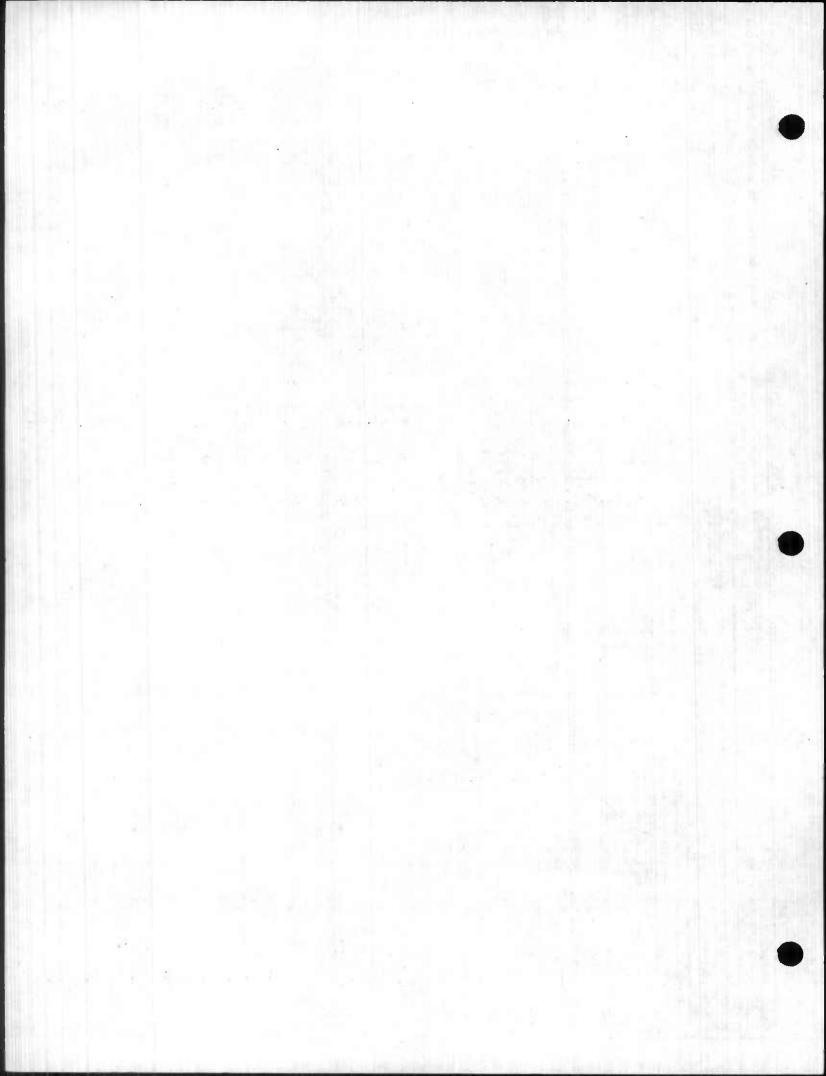
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State Registrar

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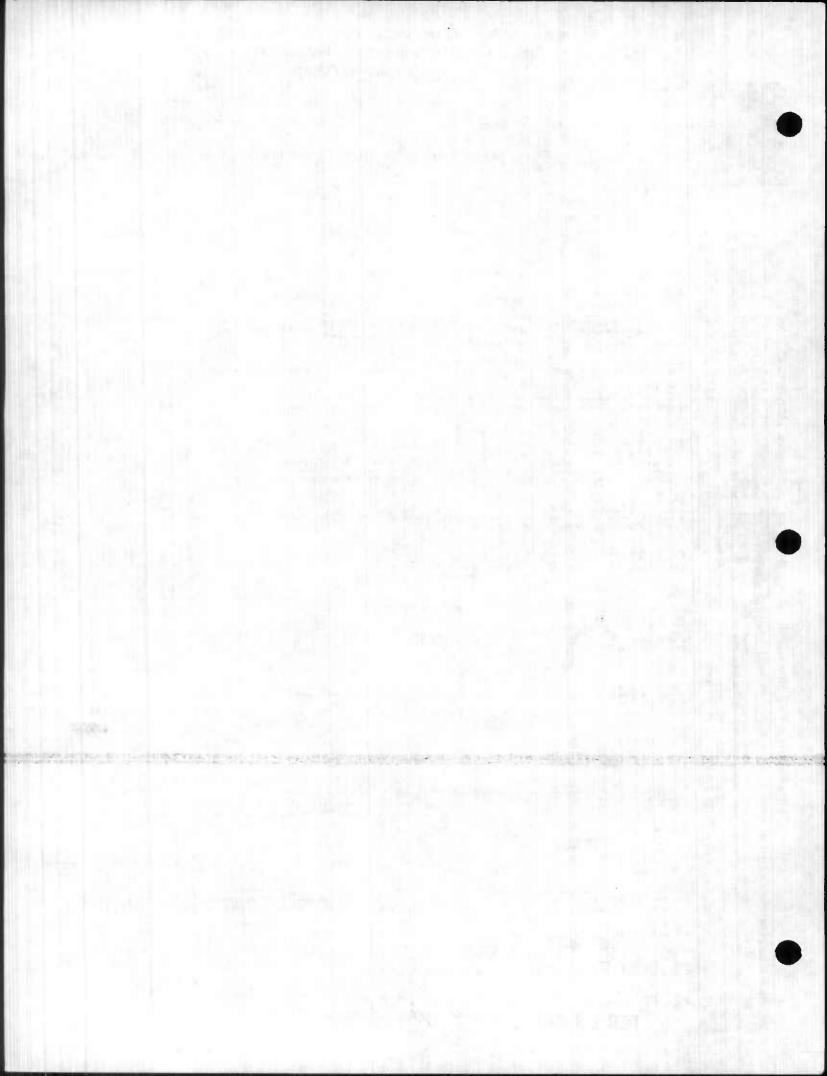
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State of Maryland / Department of Health and Mental Hygiene	
Certificate of Death Reg. No.	10.00

				Ce	rtificate	of of	Death			Reg. No.		
	1. Decedent's Name (First, Mic	ddle, Last)							2. Date of De Month		Voor	3. Time of Death
Physician Medical/	20.024 20 1120	chaels							Decembe	er 15	2000	1:30 a.m
Examiner	de Casilita Nama /// mat featitus	tion, give street and i	number)				4b. City, To	wn, or Lo	cation of Deat	th 4c. C	County of Death	1
	Casey House						Rockv:	ille		Mon	tgomer	у
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under Months	1 Year Days		24 Hrs. Min.	8. Date of Bir (Month, De April	rth ev. Year)	9. Birth	place (State or Foreign
Director	167-24-7589	1 M 2 □ F	80) Yrs.			110010		April	1,192	20	PA
2 .	Usual Residence of Decedent 10a, State 10b, Cour	h.	100 Ci	ty, Town or Lo	postion							10d. Inside City Limits
aryla aryla det	1 100	gomery	100.01	Rocky								1 ☐ Yes 2 🛣 No
or 28a-fa be notified	10e. Street and Number	30mery		ROCKV		Code				10a Chia	en of What Cou	onto O
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ther death in the	12012 Old Bri		ecedent Ever in U	10 12		852	Hienanic Ori	ain? (Sn	acifu Vas or N	Unit	ed Sta	tes can Indian
tar di ttem ttem	11. Marital Status 1 ☐ Never Married 2 ☑ M	Armed	Forces?	,3.	If Yes, speci	ify Cub	an, Mexicar	, Puerto	ecify Yes or No Rican, etc.)		Bleck, White	etc.
P. o. o.		If Yes,	s 2□No Give r Dates: 43-4		1□ Yes 2	No K	Specify:			S	Specify: W	hite
		lent's Education	43-4	16a. Dece	dent's Usua	Occu	pation	194		16b. Kind	d of Business/I	ndustry
ed within 72 ho ygiens. er than "natur r, the Medical.	(Specify only hig Elementary/Secondery (0-12	hest grade complete	d) a (1-4or 5+)	(Give	kind of work DO NOT us	k done	during mos	t of work	ing			
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Mental Mental Mental Med of Mental Med of Mental Med of Mental Med of Mental Me		owski.					F	Eva I	Kida			
2 sho and h is me	19a. Informant's Name/Relation	onship (Type, Print)		19b. Maili	ing Address	(Stree	t end Numbe	er or Rur	el Route Numb	ber, City or	Town, Stete, Z	(ip Code)
	Emma Michaels/	Spouse		1201	2 01d	Br	idge I	Road	, Rockv	ille,	MD 208	352
五五百	20a. Method of Disposition			Place of Disponentery, cre	osition (Nameros)	e of her pla	ice)	I	Dec. 18		ation - City or 1	
mit. Pages 1. partment of He portant: If liter y injury or oth os.	1 X Burial 2 Cremation 4 Donation 5 Other			klawn	Memor	ia1	Park		2000	Rock	ville,	MD
emit. Page epartment o reportant: If ny injury or nos.	21. Signature of Funeral Servi	ce Licensee		2	2. Name and	Addre	ess of Facilit	by D - I	7-1 17	1	**	
88288	TEACH A.	Freeer		D	eer D	ark	Drive				MD 208	10 East
	23a. Part1. Enter the disease shock, or heart failure. L	or complications that	it caused the dea	th. Do not en	ter the mode	of dy	ing, such as	cardiac	or respiratory	arrest,	FID 200	Approximate Interval Between
Physician	Shock, or near failure. L	ist only one cause of	n each line.								1	Onset and Death
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Exa iner	resulting in deeth)	a		or as a conse		-						8 Months
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bed by												****
The lew requires rate has been sign, page 2 should be										s an autops iormed?	, 1	Were autopsy findings available prior to completion of cause
lew responses by 2 st		77										of death?
yalclan: The levis certificate has director, pege 2									10	Yes 2 🔀	No 1	I□Yes 2□No
Physician: The lew requires this certificate has been signed in director, page 2 should be considered by	25. Was case referred to med						26. Place	of Deal	h (Check only	one)		
this ce el dire	1 Yes 2 No		Inpatient 2	ER/Outpatie		^		ursing Ho			Other (Spec	Hospice
ng P	27. Manner of Death 1 ☑ Naturel 5 ☐ Pen	ding 28a. Da	te of Injury lonth, Dey Year)	28b. Time o		Bc. Inju			28d. Describe	how injury	occurred	
tal or Attending P is after deeth. al Director: After ted in by the funer certification:	2 Accident Inve	stigation			М	1	Yes 2	No				
or Attendi after deeth Director: A J in by the f	3 Suicide 6 Cou dete	mined 289. Pla	ace of tnjury - At hilding, etc. (Speci	ome, farm, st	treet, factory	, offica			28f. Location City or To	(Street end own, Stete)	Number or Hu	urel Route Number,
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To the Hospital or Attending Ph within 24 hours after deeth. To the Fureral Director: After th completely filled in by the funeral Medical Certification:		and m	anner stated.									
	29b. Signature and title of cert	01	1 ~	100	290		se number				signed (Monti	
16	2	1. to	me	MID		DO:	9470			Decem	ber 15	, 2000
	30. Name end address of pers									1/D 0	0005	
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DHMH 16 Rev 6/95

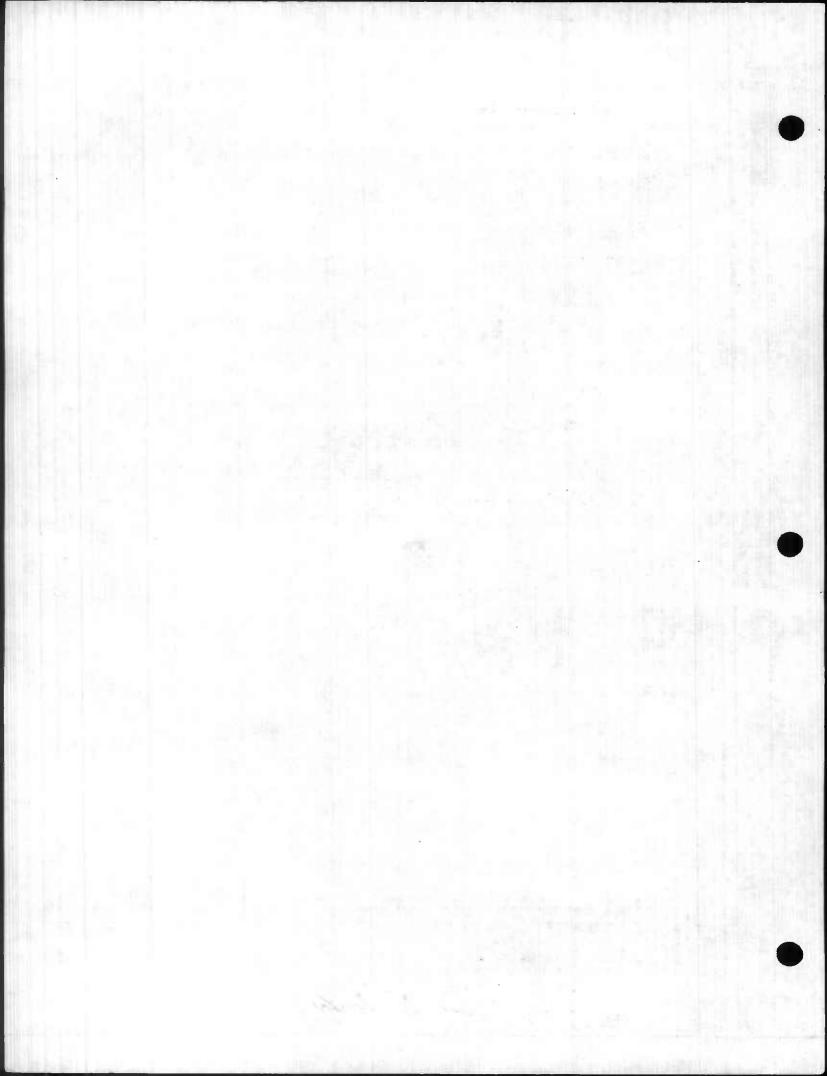


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** Mary Lyola Melville December 16, 2000 9:20 pm /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Sacred Heart Home, Inc. Prince George's Hyattsville If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year Birthplece (State or Foreign Country) 6. Sex **Funeral** Hours Months Deys 1 M 2 F Yrs. 95 Director Aug 12, 1905 212-74-3704 Pennsylvania Usual Residence of Decedent Menyland 10a. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County "natural", or Nems 23a or 28a-f ahow edical Examiner mast be notified at 1 Yes 2 No Directo Maryland Worcester Ocean Pines tha 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code with 2 Crab Cay Court 21811 Funeral USA death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Maritel Status Bleck, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White by 3K Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) 72 filed within 7 Hygiene. than College (1-4or 5+) Elementary/Secondery (0-12) Homemaker Own Home other 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fili Department of Health and Mental Hy Important: If Item 27 is marked oth any July or other traumatic event Dates. 17. Fether's Neme (First, Middle, Last) Be Lawson B. Mellott Elizabeth Flowers 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) Elizabeth M. Cianci/ Daughter 2 Crab Cay Court, Ocean Pines, MD 21811 Baitimore, 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete Buriei 2 Cremetion 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/19/00 Silver Spring, MD 21. Signature of Feneral Service Lice _22. Name end Address of Facility
Francis J. Collins Funeral Home, Inc. obul a 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Septicemia Days Examiner Due to (or es e consequence of): Pressure Ulcer l Week Examir attending physician and for use as the bunal-trensit cartificata be axecuted Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Advanced Senile Dementia Years Physician/Medicai Due to (or es e consequence of): 88 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. o. that tha 1 Yes 2 No 3 Probably 4 Unknown 0 Records, by requires 24b. Were autopsy findings eveilable prior to been si 24e. Wes en eutopsy performed? Completed completion of cause of deeth? We paga 2 cartificate has The 1 Yes 2 No 1 Yes 2 No Division of Vital Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XXNo /tel or An.
/rours after death.
/rai Director: After n.
/in by the funeral dir 10 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury Certification: 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 ☐ Coutd not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, tarm, street, tectory, office building, etc. (Specify) To the Hospital or Ar within 24 hours after To the Funeral Direc completely filled in by 4 ☐ Homicide X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29e. Certifier niner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only cons) 29b. Signature and 196 of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 22780 December 18, 2000 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Peter M. Schissler, MD 7500 Greenway Center Drive, Greenbelt, MD 20770 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

Registrar

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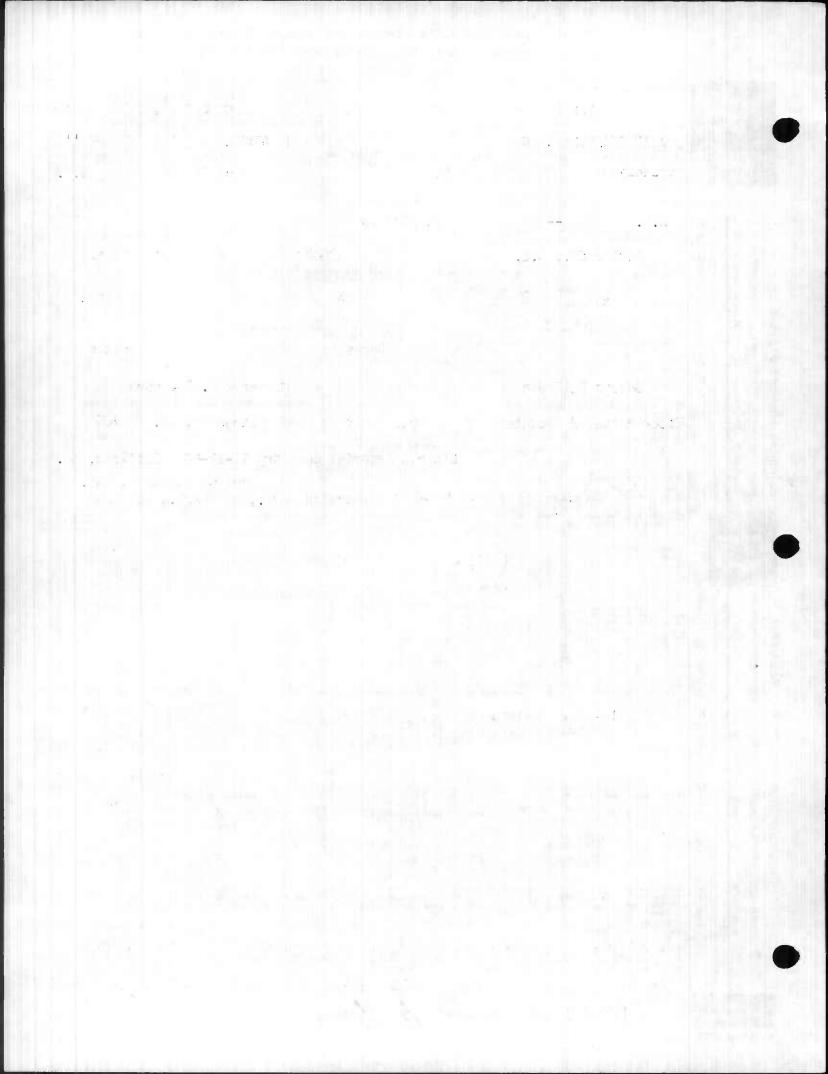
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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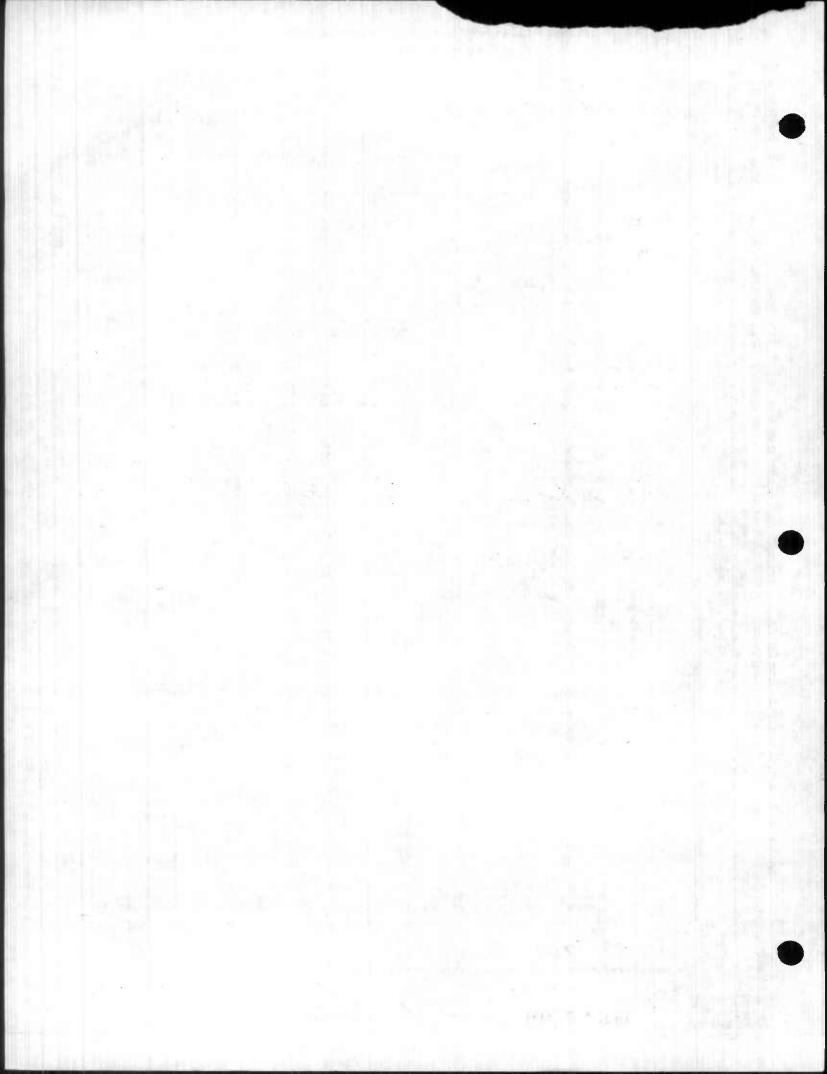


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Day **Physician** Joseph Gabriel McIntyre December 13, 2000 1:30 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 13305 Travilah Road Potomac Montgomery If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1 ₩ 2 □ F Months Days Hours 272-07-4802 Yrs. Director 85 March 25, 1915 Ohio Usuel Residence of Decedent x 28a-7 show a notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo Maryland Montgomery Potomac 200 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? then "netural", or items 23s or the Medical Examiner must be 13305 Travilah Road 20854 United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. hours after 1 ☐ Never Married 25 Merried Maryland 21215-0036 1 Yas 2 No Specify: Specify: by 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 filed within 7 Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) Superintendent Construction 12 18. Mother's Nama (First, Middle, Meiden Sumame) 17. Fathar's Nama (First, Middla, Last) Be should be and Mental marked Owen McIntyre Bridget Gallagher and last 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Coda) parmit. Pages 1 and 2 at Department of Health arr Important: If Nem 27 is r any Injury or other traus 13305 Travilah Road, Potomac, Maryland 20854 Thelma M. McIntyre/Wife Baltimore, 20b. Placa of Disposition (Name of cematery, cremetory or other plece) Dec. 15, 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2000 Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Chase, Inc. Bethesda, Maryland 20814-3501 21. Signeture of Funaral Service Ligenses M00198 0 23a. Pert1. Enter 11 disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or helm teilure. List only one cause on each line. Onset end Death **Physician** /Medical Immediate Ceuse (Final Years Emphysema diseesa or condition rasulting in deeth) Examiner Dua to (or as a consequenca ot): Examiner Pneumonia Days attending physician and for use es the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting In death) Last Due to (or es a consequence ot): Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. detached the signed by Dementia, Parkinson's Disease, Osteoporosis 1∑ Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy tindings eveilable prior to complation of causa of deeth? 24a. Wes en eutopsy pel should Depression, Cerebral Vascular Disease peen has 10 2 page Old Strokes, Colon Cancer 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this cartificate Division of Vital Hospital or Attending Physician: 25. Was case reterred to medical Be 26. Placa of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Home 5 Nesidanca 6 ☐ Othar (Specify) 10 1 Yes 2 No funerel 27. Menner of Death 28e. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Panding investigation 1 Neturel ours after death. eral Director: Aft filled in by the fur 1 Yas 2 No 2 Accident 28t. Location (Street end Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 6 Could not be detarmined 28a. Place of Injury - At homa, ferm, street, tectory, offica building, atc. (Specify) 4 | Homicida within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier edical (Check only one) To the 29b. Signeture and title of certified 29c. Licensa number 29d. Date signed (Month, Day, Year) December 14, 2000 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Eric R. Brodsky, M.D. 15215 Shady Grove Road, Rockville, Maryland 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Denema Registrar DEC 1 9

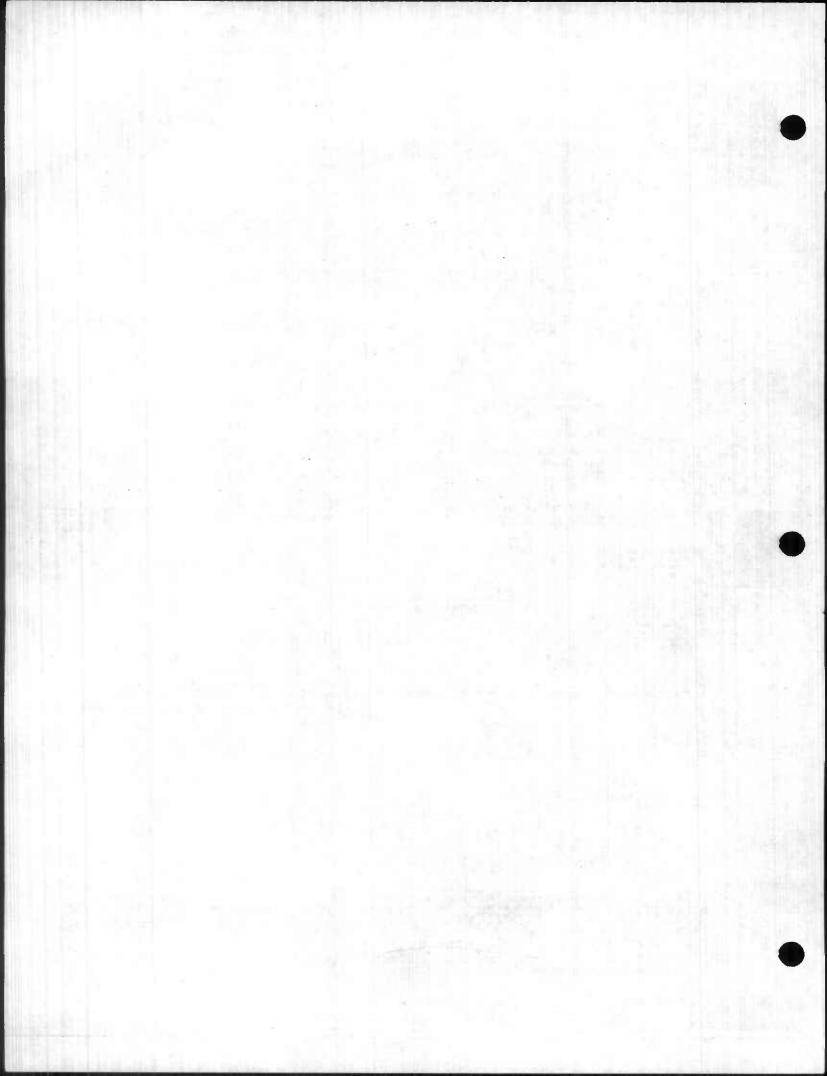
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DHMH 16 Rev 6/95

ORIGINAL



1. Decedant's Nama (First, Middla, Last)

Sharon Lea McCary

4a Fecility Nama (If not institution, giva street and number)

Physician

/Medical

Examiner

Dey 16, 2000

4c. County of Deeth

3. Tima of Death

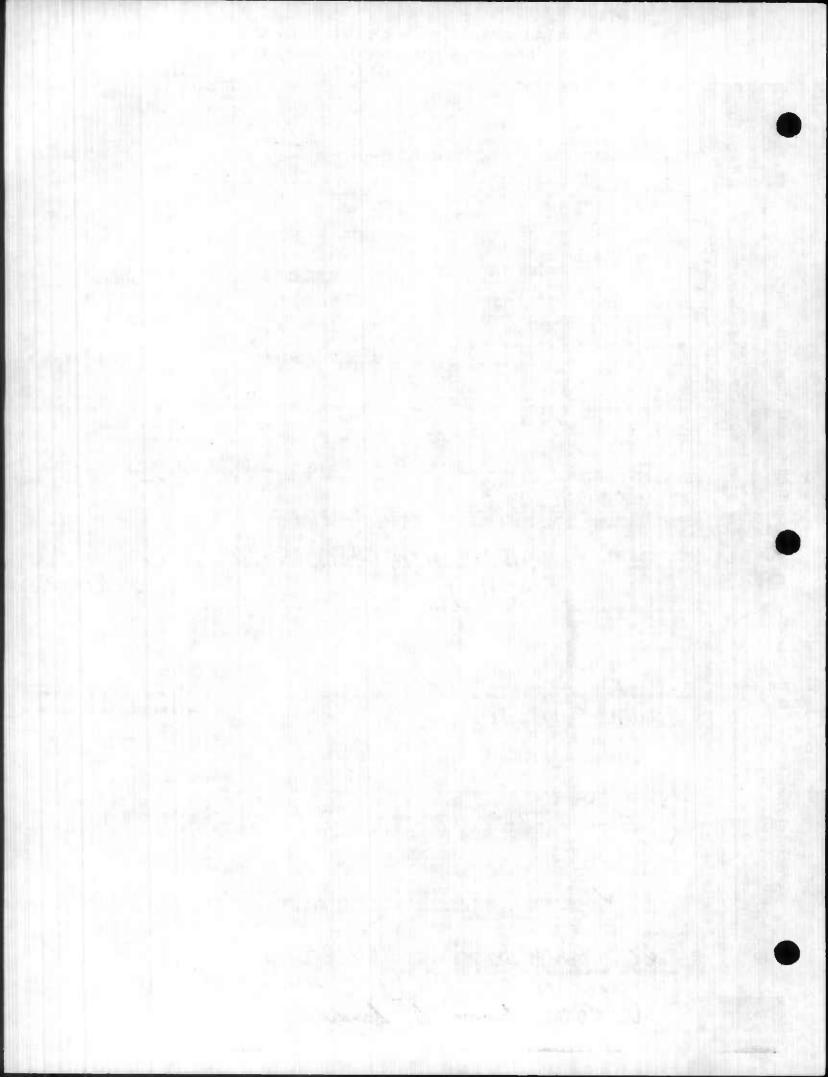
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2. Date of Death Month

December

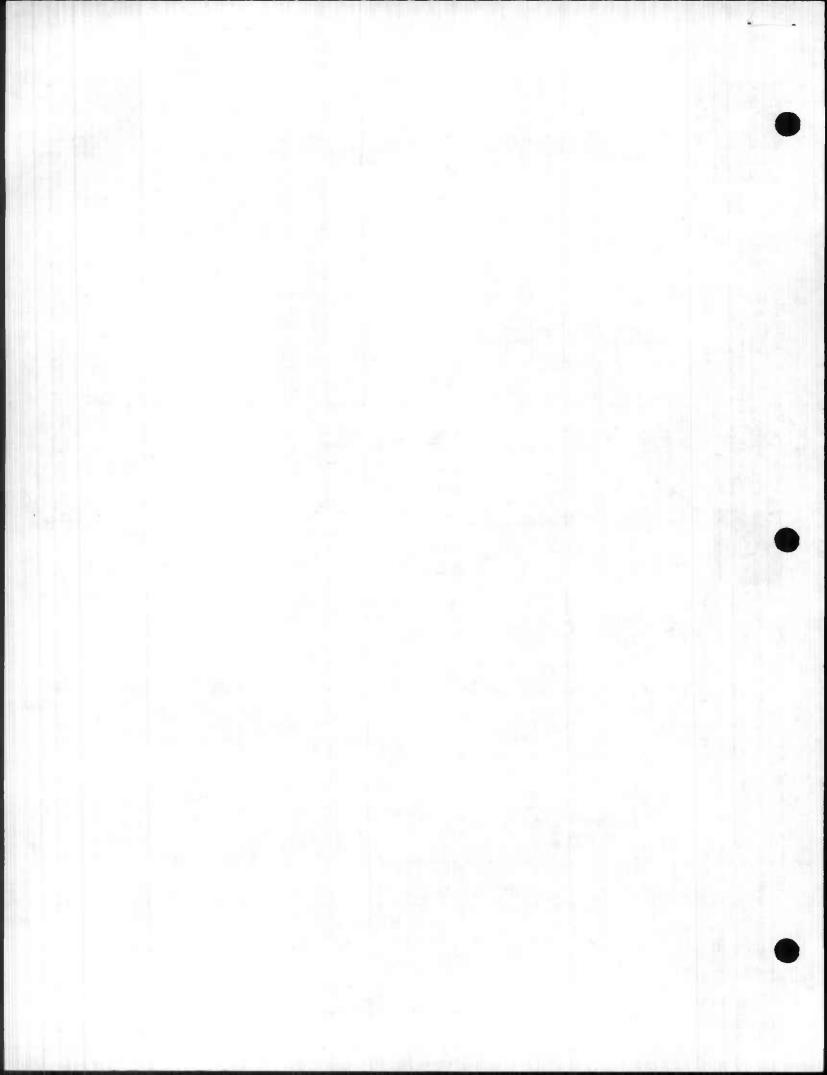
4b. City, Town, or Location of Death

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		/Medical Examiner		Immediata Causa diseese or condition resulting in deeth)	on	a. ME	Due t	177-1 to (or as a co	7 C/NC onsequence of):	CINUS.	ARCOM	1A 0	OF	10 4100
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	68760,	oe ex	E	Sequentially list co if any, laading to in causa. Entar Unde Ceuse (Disease or that initiated evants	erlying									
pm	876	death certificate be e. e attending physician ed for use as the buria	dice	that initiated evants rasulting in death)	s Last	<u></u>	Due to	to (or as a co	nsequence of):			n.		
	9 X	ing p	Me			d								
1.8	Вох	attending for use as	lan			-								
-	P.O. I	the de	/sic	Part It. Other signif	ficant conditio	ns contributing to de	eath but not	rasulting In 1	tha undarlying causa	givan in Part I.	23b. DI	d tobacco us	s contribu	ute to the cause of death
0000		that ed b	by Physician/Medical	RENI	AL F	AILUR	E				- 10] Yes 2 ☐		Probably 4 Unknow
15/16	Scord	v requ	Completed								24a. Wa	as an eutopsy formed?	24	 Ware autopsy findings available prior to completion of cause of death?
	m.	ysician: The lav is certificate hes director, page 2	E								10	Yas 20	10	1 Yas 2 No
Sharon	tal		Be C	25. Was casa rafai	rad to medical					26. Placa of	Deeth (Chack only	v one)		
3	>	ysicla is cer direct	To B	axaminar?		11	Innatient :	2∏EB/Outc	petient 3 DOA	Other:	ng Homa 5□Ra		Othar /S	inecify)
7	o		T ic	27. Mennar of Deat		-	of Injury	_	ma of 28c. In			e how injury o		poony
~	0	ding it.	to	1 Natural 2 Accident	5 Pendin- invastic		th, Day Yea	ir) Inj		Vork? ☐Yas 2☐No				
uccan	ō	or Attending Physician: after death. Director: After this certific in by the funeral director,	ertifica	3 Suicida 4 Homicida	6 Could r datarm	not be 28a. Place	of tnjury - Aing, etc. (Sp	Af homa, fam becify)	n, straat, factory, offic	> 8	28f. Location City or 7	(Straat end Nown, Stete)	lumber or	Rural Routa Number,
200		To the Hospital within 24 hours a To the Funeral Completaly filled	edical Certification:	29a. Certifier (Check only one)		Examiner: On the bi			deeth occurred et the or invastigation, In m					
		within 2 To the comple	M	29b. Signatura and	titla of certifier				29c. Lice	ensa number		29d. Data s	ignad (Mo	onth, Day, Year)
	0	10		MA	Mort	negon	9		0-	2330	8	DEC.	1	7,2000
				6410 R	OCKLE	on the plated cause of the Di	21, 5	SUIT	E 625	BET	Priego, N	, N	0	20817
		Sta Registr		31. Data filed (Mon		2000	legistrar's Si	ignatura 6	Lone	at a				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

							Ce	rtificat	te of	Death			Reg. No.	y tree		
			1. Decedent's Neme (First, M	liddla, Li	est)							2. Data of De	ath		3. Time of	Death
в	Physician	-	Anthony J. Ma	atr	orogo							Dec en	Day 2	Year	131	5
	/Medical Examiner	1	4a Facility Nama (If not instit			umber)				4b. City, To	wn, or Lo	ocation of Deat		ty of Death		
	Examine	ı			HAMPS	4 0	Aver	ue		Silv	en S	orine			Beorge	15
-			5. Social Security Number		Sex	7. Age (In yrs			r 1 Year			8 Data of Bir		1	place (Stete o	
н	Funeral Director		215-48-4917		X M 2 □ F	48		Months	Days	Hours	Min.	8. Data of Bir (Month, Da	y, Year) 5, 1952	Cou	ntry)	rroragn
١	Director	-	Usual Rasidence of Decedan	t		10						march	, 1772	DC		
	land land	-	10a. Stata 10b. Cou			10c. C	ity, Town or L	ocation							10d. Inside Ci	ty Limits
	dany de d	5 7	Maryland Pri	200	George'	c c:	lver S								1 🗆 Yas	2X) No
	vith the Ma	6	10e. Street and Number	ICE	George	5 51	TVEL 3	-	o Code	-			10g. Citizen of	What Cou	nto/2	
	H S A	5											rog. Ontaon of	What Ood	yı	
	ifter death with the Maryland rema 23a or 28a-f show rings must be notified at Finnerial Director	0	8226 New Hamp	shi				209					USA		1 4	
		5	11. Marital Status		Armed F		J,S. 13.	Was Dece If Yes, spe	dent of the cify Cub	Hispanic On an, Mexicai	igin? (Sp n, Puarto	ecify Yas or No Rican, etc.)		ce - Amaricack, White,		
20	a so		Never Married 2 1		If Yes, G			1 ☐ Yes	2 XNo	Specify:			Speci	y: Wh	ite	
5-0020	"natural", or le	2 -	3 Widowed 4 Divo		Yaar or I	Datas:										
5	72 par		15. Dece (Specify only hi)	(Give		ork done	during mos	t of work	ing	16b. Kind of E	Business/In	idustry	
2121	within ene.		Etementery/Secondary (0-1	2)	Cotlege	(1-4or 5+)		DO NOT u	ise retire	(d)						
	Hygie ther the there the	5 -	12				Sale	S							Supp1	ies
P	be filed within tal Hygiene. Id other than event, the Hygiene.		17. Father's Name (First, Mid	dla, Lasi	1)					18. Moths	ar's Nam	a (First, Middle	Maiden Suma	ma)		
N S	should be filed very marked other turnstic event, to		Arsenio J. Mas	stro	rocco					Mary	Mos	sca				
Maryland			19a. Informant's Name/Ralat	ionship ((Type, Print)		19b. Meit	ing Addres	s (Street	t and Numb	er or Rur	al Route Numb	er, City or Town	, Stata, Zij	o Code)	
	ges 1 and 2 should to f Health end Mer If Nem 27 is marks or other traumatic		Emilio A. Mas	stro	rocco /	Brothe	r 3325	Sud1	ers	ville	Sout	h, Lau	rel, MD	207	24	
ore	A He He	1	20a. Mathod of Disposition			20b.	Place of Disp	osition (Na	ma of			Data	20c. Location			
Ĕ	Pege at: #		1 X Burial 2 ☐ Cramati			State	orge W			,	tets	12/20	Adelph	4 MD		
Baltimore,	permit. Peges 1 and 2 Department of Health of Important: If Item 27 Is any Injury or other tra ance.	-	21. Signature of Albertal Serv		_											
Ba	Depa Impo any l		NA Mark	1)	1/11	5							l Home,			
		-	your!		14/-	_	5	00 Un	ive	rsity	Blvc	1, W, S:	ilver S	pring		
			23a. Per 1. Entar tha disaasa shock, or haart faitura.	List only	one cause on	caused tha dea aech lina.	ith. Do not en	tar tha mod	de of dy	ng, such as	cardiac	or respiratory e	rrest,	į.	Approximate Intervet Bet	ween
В	Physician				4.	,					1			1	Onset and I)eath
	/Medical Examiner	1	tmmediata Cause (Final disaasa or condition resulting in daath)		At	Lerosc	(ero7	700	mo	roug	cul	an ais	ena			
п			resulting in oaatii)				or as a conse							1	100	
	executed in end riel-transit			-	b									i		
	icete be executed physician end s the buriel-transit		Sequentially list conditions,			Dua to (or as a conse	quence of):						t		
00	Slan vuriel		Sequentially list conditions, if any, leading to immediata causa. Enter Undarlying Cause (Disease or injury	"												
68760,	certificate be examing physician use as the burle		thet initieted avents rasulting in death) Last	1	0.	Dua to (or as a conse	quence of):								
9	Mex Mex													1		
0	requires that the death certific been signed by the attending p should be detached for use as letted by Physician/Mee				d											
. 8	death e atter ed for u		Part II. Other significant con-	ditions	contributing to d	seath but not re	sulting in the u	underlying o	ceusa gi	ven in Part I		23b. Did	tobacco use c	ontribute f	o the cause o	of death?
P.0	of the death ce d by the attend stached for us.											10	Yes 2 No	.3 Pro	bably 4	Unknown
	es that igned be dete															
Ď	requires hould be hould be												en autopsy	24b. W	ere autopsy f	indings
00												perto	rmed?	CC	vailable prior to emptation of condenses.	
Re	The law requires the has been s page 2 should Completed													-		
a	icate h											10		1	☐ Yes 2☐	No
of Vital Records,	Physician: The level this certificate has rai director, page 2: To Be Comp.:	1	25. Was casa referred to med examiner?	lical	Hospitet:				100	hor		h (Check only				
of	Z S D		1⊒ Yes 2□ No		1 1 1	-	ER/Outpatie		UA	4LIN	ursing Ho		dence 6 00		fy)	
	the roll	1	27. Menner of Death 1 ☐ Natural 5 ☐ Pa			of tnjury oth, Day Year)	28b. Tima o		28c. Inju Wo			280. Describe	how injury occu	irred		
Sio	Attending or deeth. actor: After fune by the fune fification		Z LI Modidani	estigatio				М	1]Yes 2□	No					
Division	tal or Attending P rs after deeth. al Director: After t led in by the funer: Certification:			amined	28a. Place	e of Injury - At h ling, etc. <i>(Spec</i>	noma, farm, st ify)	reet, factor	y, office			28f. Location (City or To	Street and Num wn, Stata)	iber or Run	al Routa Num	ber,
٥	tel or is after in the control or in the control															
	n 24 hours n 24 hours ne Funeral pletaly filled				nysician: To the miner: On the b											
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completaly filled in by the funeral Medical Certification:		one)	LAdi	end mar	nnar stated.	and and I	- wonyand	-, mr my l	oprimori, uda	500011	ou at the third,	-att and place	, and dua t	- una causo(S	
	To the comple	1	29b. Signeture end titla of cer	tifier	1			29	c. Licen:	se number			29d. Data sign	ed (Month,	Day, Year)	
	12		Salvada	1/	LATE	Do		1	400	559	27		Decem	ber :	20 20	00
	10	3	30. Nama and addrass of pars	on who	completed cau	sa of death (Ite	m 23a) (Type.	Print)					Decem	1	1	
			Salvadar S	12	ater	3001 A	tox sit	al .	Dri	re C	Lar	el 1	an la	Nd	2078	
	State	3	31. Data filed (Month, Day, 4)	ear)	32.	Registrar's Sign	atura					dr	-	. 07		
	Registrar		DEC 2	1 21	000 4	specimes.	B.	100	aks							



Physician /Medical Examiner

attending physician end for use as the burial-trar

signed by the a

Deed hes 16 2 s page

this certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, t

The law requires that the deeth certificate be executed

Box 68760

P.O.

Records,

Division of Vital

Physician/Medical Examiner

by

Completed

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Certification:

edicai

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

Funeral

Director

r 28a-f s

ed other than "natural", or items 23s or event, the Medical Exeminer must be r

72 hours after

filed within

Hypiene.

upper 1 and 2 should be file unsportment of Health and Mental Hu-any Injury or other 27 is mental.

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZURE DISORDER

1 Yes 2 No

28d. Describe how injury occurred

1 ☐ Yes 2 No

25. Was case referred to medical Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4₺ Nursing Home 5 Residenca 8 Other (Specify) Injury at Work?

1 Yes 2 No

26. Place of Death (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, Stele)

29a. Certifier (Check only one)

1 Neturel

3 Suicide

2 Accident

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and manner as stated. niner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signafura and title

31. Date filed (Month, Day Year)

DEC

29c. Licansa number 105-645-4

29d. Date signed (Month, Day, Year) 2000

30. Name and address of person who comiplated cause of daath (Item 23a) (Type, Print)

2000

DR. YAZDANI 11418 LIVINGSTON ROAD, FORT WASHINGTON, MARYLAND 20744

ORIGINAL

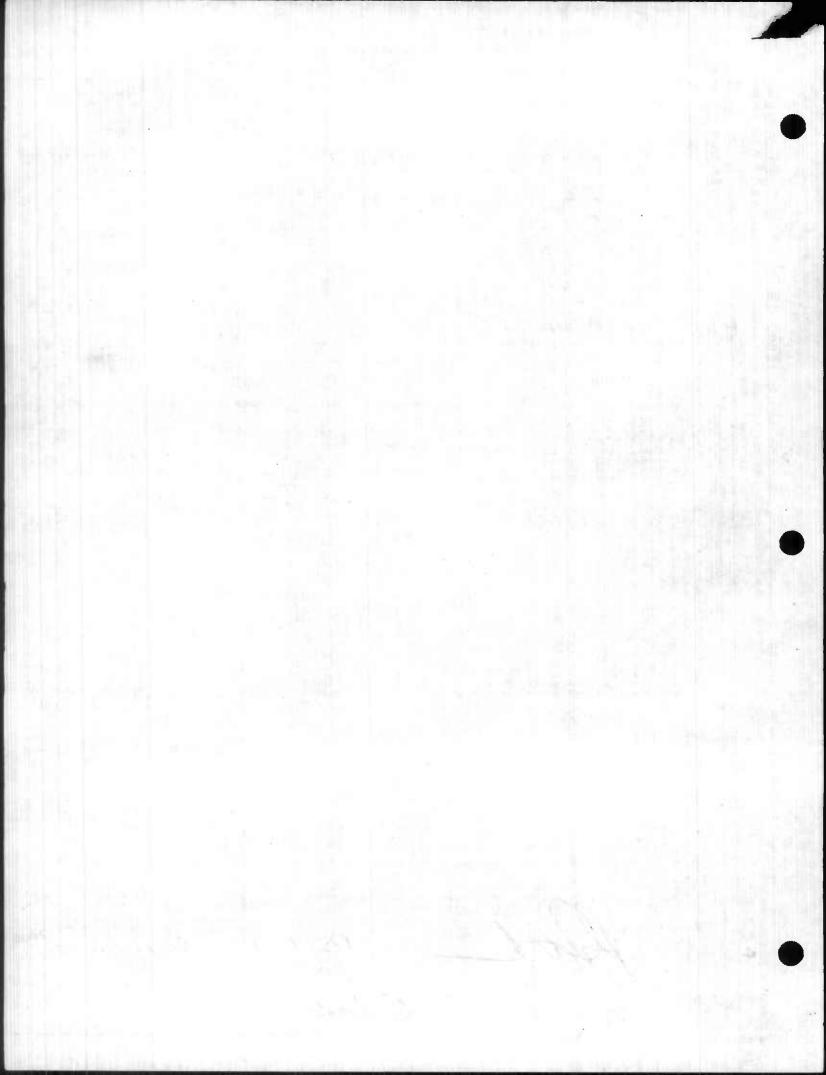
State Registrar 32. Registrar's Signature



1

5 Pending investigation

6 Could not be determined

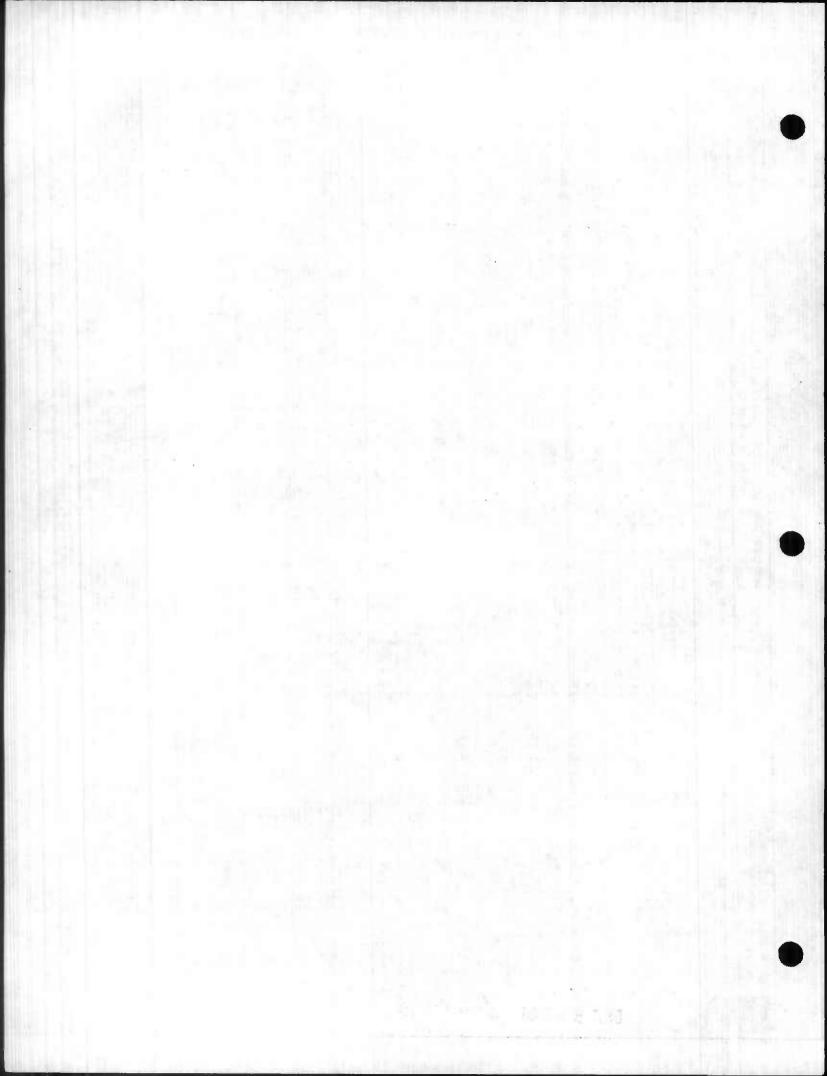


State of Maryland / Department of Health and Mental Hygiene 1, 2 | 9 0

					, , , , , , ,	Cer	tifica	te of	Death	,	Reg. No.	الما الما	
		1. Decedant's	Name (First, Middla, La.	st)		3 6 7 8				2. Dete of De Month		Year	3. Time of Death
	Physician /Medical	Mary A	gnes Mas)				4b. City, Town, or	Decemb	er 17,		1:30 pm
	Examiner	De Contraction de	Care- Silve	ACAI COMPANY					Silver S			tgomer	
-	Funeral	5. Social Secur	rity Number 6. S	ax 7. A	ga (In yrs. i	ast birthday)	If Unde	r 1 Year Days	If Under 24 Hrs	8. Dete of Bir	th		placa (Stata or Foraign ntry)
I	Director	219-68 Usuat Rasiden	-2785	□M 2ÅDF	92	Yrs.	MOHITIS	Days	Hours Will.	July	9,190	8 Illi:	nois
	yeard M M	10a. Stata	10b. County		10c. City	, Town or Loc	cation				100	1	10d. Inside City Limits
	Many Many Many Many Many Many Many Many	Marvla	nd Montgome	rv	Silv	er Spr	ing						1 ☐ Yes 2X No
	or 28e-f s be notified	10e. Street and						Coda			10g. Citizen	of What Cour	ntry?
			Birch Sprin	gs Court			209	05		Man 1	USA		
36	ars after death vir. or here 23s zaminer must		tus Married 2 Married ved 4 Divorced	12. Was Decedant Armed Forces 1 Yas 2 If Yas, Giva Yaar or Datas:	?				lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Americ Black, Whita, ecify:	
8			15. Decedent's Ed			16a. Deced	ant's Usu	al Occur	pation		16b. Kind o	of Businass/In	
21215-0036	od within 72 ho yglene. ser than "naturi c, the Medical.] Completed	Flomostan/	Specify only highast gra Secondary (0-12)	da completed)	5.1	(Giva I lifa, D	kind of wo	ork dona ise retire	during most of wo d)	rking			
212	the the	12		Cotlega (1-4or	3+)	Home	make	r			Own I	Home	
P	tal Hydra d other event.		eme (First, Middle, Last)						18. Mothar's Na	ma (First, Middla,	Maiden Sun	name)	
Maryland	Menta Menta Mice	John F	itzgerald						Lucy Tu	eth			
an	and is ma		t's Nama/Relationship (Typa, Print)		19b. Mailin	g Addras	s (Street	and Number or R	ural Route Numb	er, City or To	wn, Stata, Zip	Code)
	Ham 27 other tr		n Keiser /	Daughter					Springs C				, MD 20905
Ore		20a. Mathod of	f Disposition 2 □ Cramation 3 □	Ramoval from Stata	0	lace of Dispos ematary, cram	natory or	ma of othar pla	сө)	Data	20c. Locati	on - City or To	own, State
E	Page Mark III	4 □ Donat	tion 5 Othar (Specify	1)					metery	12/21/00	Silve	er Spr	ing, MD
Baltimore,	permit. Pa Departmen Important: any injury ance.	21. Signatury	of Funeral Service/ Vert DK	Ja-		Fr	anci	s J.	ss of Facility Colling				g, MD 20901
	Physician	23a. Part Y Er shock, or	ntar tha disaasa, or com r heert failure. List only	olications that cause ona causa on aach i	d tha daeth	. Do not anta	ar tha mo	da of dyi	ng, such as cardia	c or raspiratory a	rrast,		Approximata Intarval Batween Onsat and Death
4	/Medical	Immediate Ce diseasa or cor	ndition	a Urinary	Sens	sis							Days
	Examiner	rasulting in da	ath)	а		r as a consequ	uance of)	:				1	
-	axecuted in and faltransit	BB		Dehydra	tion							1 .	Days
	the attending physician and hed for use as the burial-transit vsician.	Sequentially li	st conditions,		Dua to (or	r as a consequ	uance of)	:					
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387	g physicia as the bu	rasulting in de	vants ath) Lest		Dua to (or	as a consequ	uance of):					1	
	ding se a			d				W.					
Box	death cer e attendir ed for use	B	1			h:- 1 a			- 12 F2-14	non Did	**************************************		a the course of death 2
P.O.	= >0 -	Part II. Other s	Ignificant conditions o	ontributing to death t	out not rest	iting in the un	ndarrying	causa gr	van in Part t.		Yes 2 1		to the causa of death?
	es that igned b be dete by P!										108 201	0 0 110	outry vigionalionii
Records,	v requir				9/1						an autopsy ormed?	6/	fare autopsy findings vailable prior to omptation of cause daath?
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Vital	ysician: The laving certificate has director, page 2		rafarred to medical						26 Place of De	ath (Check only			_ ,,,,
>	Physician: this certifical director,	axaminar?		Hospital: 1 ☐ Inpeti	ant 2	ER/Outpatient	1 3 D	OA OI	h me:	Homa 5 ☐ Rasi		Othar (Speci	ify)
0	Para :	27. Mannar of		28a. Date of Inju	ury	28b. Tima of		28c. Inju Wo		28d. Dascribe			
0	Attanding 8 or death. Sctor: Atter by the funer iffication:	1 🖾 Natura 2 🗆 Accida	torre established a		y rout/	Injury	M.		Yas 2□No				
Division of	is after death. In Director: After the dinby the funers Certification:	3 Suicid 4 Homic		28a. Flace of in	jury - At ho lc. <i>(Specif</i>)	ma, farm, stre	et, factor	y, office		28f. Location (City or To		umber or Rur	ral Routa Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun	29a. Cartifiar (Check one one)		ysician: To the best niner: On the basis of and mannar si	f axaminat								
	withir To the comp		end title of ception	~			29	c. Lican	sa number	- 1 - 1 - 1	29d. Data si	gned (Month,	Day, Year)
	10		161	0/1	3			D254	22	1	Decem	ber 19	, 2000
		30. Nama and	addrass of person who	complated causa of	death (Itam	23a) (Type, I		223-			Decem	201 17	, 2000
		Robert	Y. Maggin,	MD 1395	2 Bal	timore	Roa	d. I	aurel. M	D 20707	7		
	State Registrar	31. Dete filed	(Month, Day, Year) DFC 2.1 2	32. Flogist	rar's Siona	ture A.	10	cell	21				

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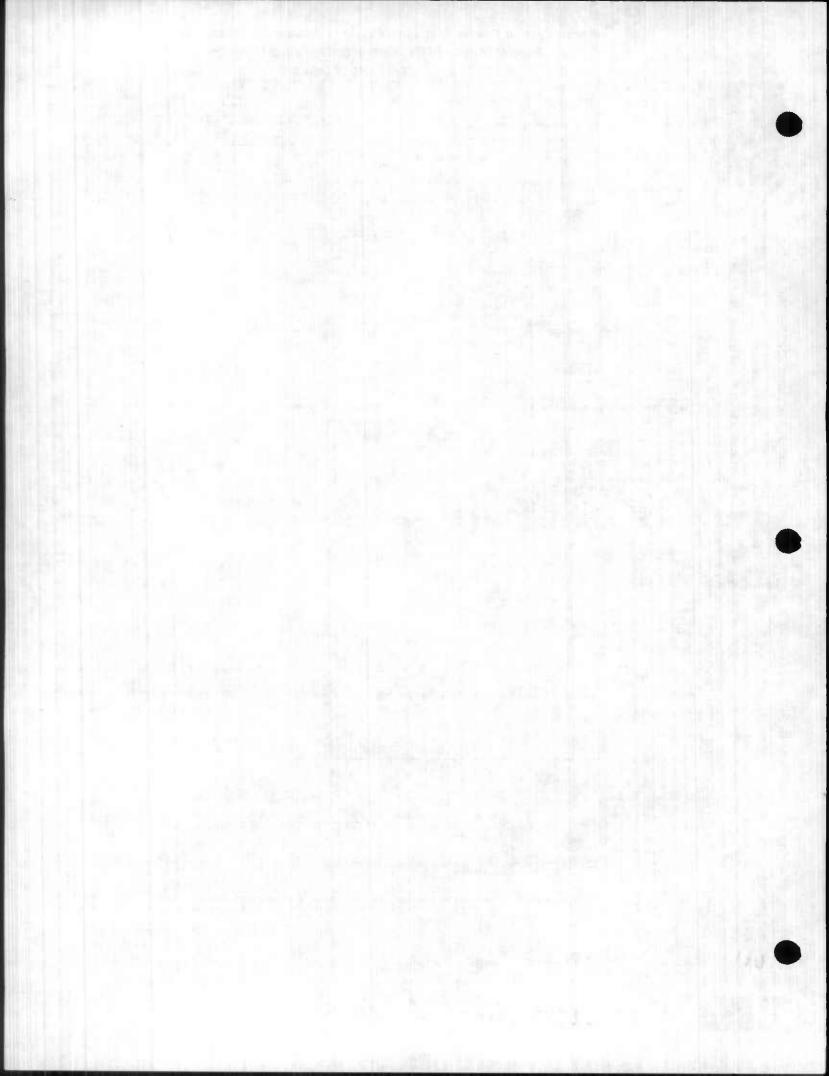
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 1 2 9

				Certifica	ate of	Death		Reg. No.	1 Life (.	1 2 1
Physician	Decedent's Name (First, Middle, Last THOMAS KINTON		ALE				2. Date of Do Month	eath Dey	Year	3. Time of Death
/Medical	4a Facility Name (If not institution, give					4b. City, Town,	DEC.	18, 2000 h 4c. County		6:00 PM
Examiner	SHADY GROV		IST HO	SPITA:	L	ROCK	VILLE		TGOM	ERY
Funeral Director	5. Social Security Number 6. S 364-32-8671		e (In yrs. lest b		der 1 Year		lin. 8. Date of Bi (Month, D SEPT.	rth ey, Yeer) 7,1921	9. Birthpla Countr TENNI	ace (Stete or Foreigny) ESSEE
Aeryland I ahow ed at	Usuel Residence of Decedent 10a. Stete 10b. County MARYLAND MONTGON	MERY		vn or Location	RG				100	d. Inside City Limits
th with the Meryle 23a or 28a-f should ust be notified at rai Director	10e. Street and Number 9000 EDGEWOOD DRI	VF.		10f.	Zip Code	7		10g. Citizen of UNITED		
urs after dee	11. Merital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	10/0				(Specify Yes or Nerto Rican, etc.)	0- 14. Rad Bla	ce - American ck, White, et	n Indien, tc.
c 1 4 -	15. Decedent's Ed (Specify only highest gra Elementary/Secondery (0-12)			(Give kind of life. DO NO	work done	during most of I	working	16b. Kind of B	usiness/Indu	istry
filed withir Hygiene. ther than ent, tre		5+		AIDE				STATE I		MENT
ges 1 end 2 should be filed within it of Health end Mentel Hygiene. If Item 27 Is marked other than or other traumatic event, Dr. M. To Be Comp	17. Fether's Name (First, Middle, Last) THOMAS HARDING M						Neme (First, Middle NAH LANE		ne)	
2 sho end I is ma	19a. Informant's Name/Relationship (7	Type, Print)	19	b. Mailing Addre	ess (Street	end Number or	Rurel Route Numb	er, City or Town	, Stete, Zip C	Code)
Health Health Pm 27 ther tr	MRS. JENNIE MART	CINDALE (W				DRIVE	- GAITHE			20877
Pa ury	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif)		cemet	of Disposition (for ery, cremetory of CEMETE	r other ple	ca)	Date 12/22/0	20c. Location O ATOKA	TN.	n, State
permit. Pag Depertment Important: It any Injury o	21. Signature of Funeral Service Lican	DeVA				SS of Facility JNERAL F	HOME PARK DRIV	F - CATT	THERSE	20877
	23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused	I the death. Do							Approximate Interval Between
Physician	onoun, or mount randio. Elot only	one dade on each n	10.							Onset end Death
/Medical Examiner	Immediate Cause (Final disease or condition	ASPIR	ATION P	NEUMONI	A				2	WEEKS
	resulting In death)		Due to (or as a	consequence	of):					
nsit		b	15 FL					710-1	i	
al-trai	Sequentially list conditions, if any, leeding to immediate		Due to (or as e	consequence	ot):				1	
artificeta be executed ing physician and es the burial-transit Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initied events resulting in death) Last	c	Due to (or es e	consequence o	of):					
v requires that the deeth certific been signed by the attending i should be detached for use es leted by Physician/Me	Part II. Other significant conditions or		ut not resulting	in the underlyin	g ceuse gi	ven in Part I.	23b. Dio	I tobacco uae co	ontribute to t	the cause of death
requires that the seen signed by th hould be deteche	SEPSIS						1 🗆	Yee 2□ No	3 Probe	ably 4∑ Unknow
	ACUTE RENAL FA	AILURE				r i	24a. We per	s an autopsy ormed?	avai	re autopsy findings ilable prior to apletion of cause eath?
ysician: The lav is certificate hes director, page 2 To Be Comp	PARKINSONS DIS	EASE					10	Yes 2 No	10	Yes 2□ No
entifica sctor, p	25. Was case referred to medical examiner?	BIIOD				26. Place of I	Death (Check only			
5 0 D	1 Yes 2 No	Hospital: 1 🖾 Inpatie	ent 2 ER/C	utpatient 3	DUA		g Home 5 ☐ Res	idenca 6 □Ott	ner (Specify)	
Attending Pr r death. ector: After th by the funeral	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation		ry y Year) 28b.	Time of Injury M	28c. Inju Wo 1	ryet vrk?]Yes 2∐No	28d. Describe	how injury occu	rred	
tat or Attending P rs after death. In Director: After t led in by the funer: Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Placa of Injuding, etc.	ury - At home, to. (Specify)	arm, street, fac	tory, offica			(Street end Num. own, Stete)	ber of Rurel	Route Number,
To the Hospital or Attending Phy within 24 hours stated death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: T		yelcian: To the best of niner: On the basis of and menner sta	examinetion e							
	29b. Signature and the of curtifier					se number 3656		29d. Date signe DECEMBER		
641	30. Neme and address of person who of RAVI PASSI = 152				8 - F	ROCKVILI	LE, MARYL	AND 2085	50	
. State	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	4	bock					
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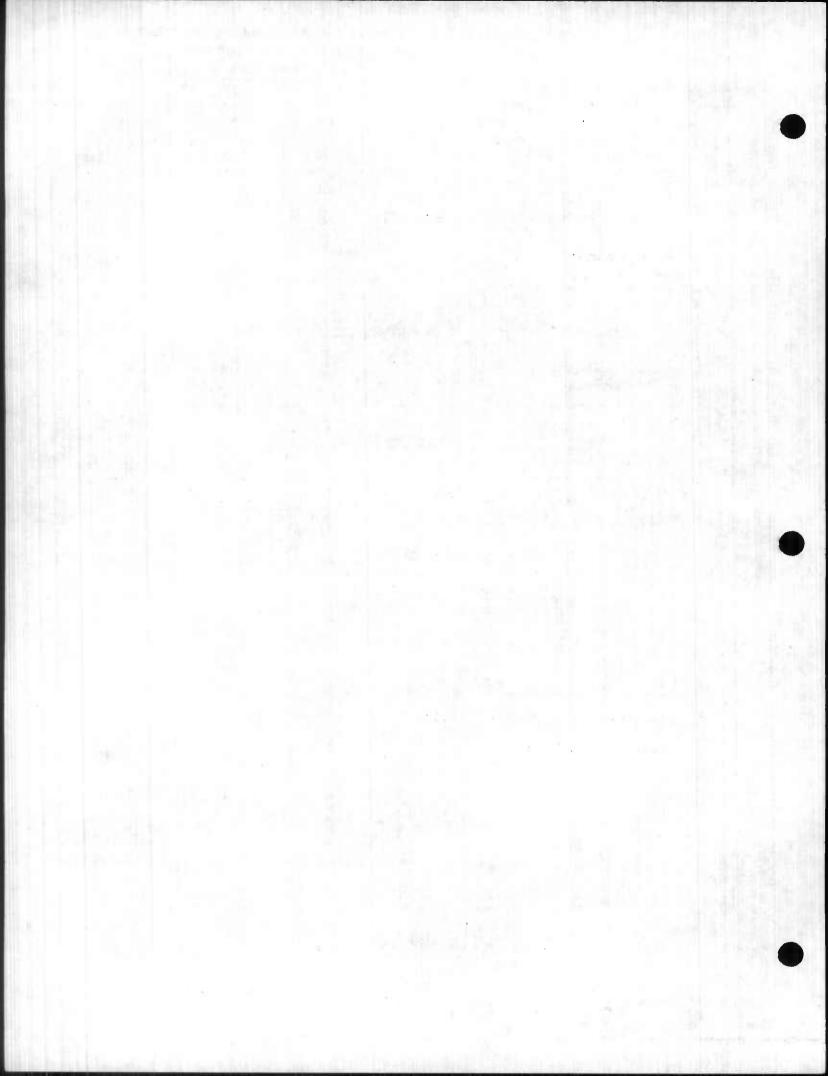
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death		R	eg. No.	46	106
HILL	1. Decedent's Nama (First, Middle, L	ast)					2	. Dete of Dea		Vaca	3. Time of Death
hysician	John Andrew M	larrama					D	Month	r 20, 2	Year 2000	10:35PM
/Medical xaminer	4e Facility Name (If not institution, g	ive street end number)			4b. City, To	own, or Loca	tion of Death	4c. County	-	
.xammer	14604 Woodcre	st Drive				Rock	kville		Mont	gome	rv
mana!			ge (In yrs. last bii	rthday) If Und	er 1 Year	If Under		Date of Birth (Month, Day			place (Stete or Foraigntry)
neral ector	023-12-8020	1X M 2□ F		Yrs. Months	Days	Hours	Min.	(Month, Day	, Year) , 1923	Color	rado
	Usual Residence of Decedent							<u>u=</u>) =0	, 1)23	00101	Ludo
ed at	10a. State 10b. County		10c. City, Tow	n or Location		1315			5 - 1 -	1	Od. inside City Limit
rai Director	Maryland Montgom	erv	Rocky	ville							1 ☐ Yes 2 ☑ N
20	10e. Street and Number	-		106.7	ip Code			1	Og. Citizen of \	What Cour	ntry?
Funeral Director											
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- Pu	11. Marital Status	12. Was Deceden Armed Forces	? WW TT	13. Was Dec	ecify Cub	an, Mexica	ngin? (Speci n, Puarto Ri	fy Yas or No- can, etc.)		ce - Americ ck, White,	
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d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	Rolea								
Be Completed	15. Decedent's I (Specify only highest g	Education reda completed)	16a	Decedent's Us	ual Occu	pation	st of working		16b. Kind of B	usiness/In	dustry
d	Elementery/Secondery (0-12)	College (1-4or	5+)	(Give kind of w life. DO NOT	use retire	id)	•				
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To E	Andrew Marrama					Ange	la Ra	ffaele			
-	19a. Informant's Name/Relationship	(Type, Print)	198	. Mailing Addre	ss (Stree	end Numb	er or Rurel i	Route Number	r, City or Town,	Stete, Zir.	Code)
	John Marrama -so			0003 Kel							
	20a. Method of Disposition	71		of Disposition (N		oau,	ric. I.		20c. Location		
	1 ☑ Burial 2 ☐ Cremation 3	Removal from State	cemete	ry, cremetory or	other ple		De	cember			
	4 ☐ Donation 5 ☐ Other (Spec	eify)	Gate	of Heave			123	, 2000			ing, MD
	21. Signature of Funeral Service Lio	arisine /		22. Name	and Addr	ess of Fecil	Robe	rt A. I	Pumphre	y Fur	neral Home
	Xtan ()	1	M00689	Rockvi	lle,	Inc.	300	West Mo	ontgome	ry Av	renue,
	23 Part Etter he disease, or con	mplications that cause	ed the death. Do	not enter tha me	da of dv	mary ng. such as	cardiac or	20850-2	2805		Approximete
	short blure. List onl	y one ceuse on each	line.								tnterval Between Onset and Death
	tmmediate Cause (Final										
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edical Examiner		Lung	Cancer							i	Months
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Û	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									1	
108	thet initiated events resulting in death) Lest	C.	Due to (or as a	consequence of):					1	
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	The Control of the Co	d								1	
5	Pert It. Other significant conditions	contributing to death	but not resulting i	n the underlying	cause o	ven in Pert	1.	23b. Did to	obacco uae co	entributa t	o the cause of deati
Physician											bebly 4 Unkno
YP	Prostate Cancer	, Chronic	Obstruct	ive Pul	mona	ry		121			
d by								24a. Was e	an autopsy	24b. W	ere autopsy tinding
Completed	Disease, Diabete	es						perfor	mad?	CO	vailable prior to empletion of causa
ldu										of	death?
200								1 U Y	as 2KI No	11	☐ Yes 2☐ No
Be (25. Wes case referred to medical			10.5		26. Plac	e ot Death (Check only or	ne)		
To	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 ER/O	utpatient 3 🗆 I	DOA OI	her: 4 N	ursing Home	e 5 ₩ Resid	ence 6 Oth	ner (Speci	(y)
=	27. Manner of Deeth	28a. Dete of Inj (Month, D	ury 28b.	Time ot	28c. Inju	iry at	28	d. Describe h	ow injury occur	rred	Established to
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edical Certification:	3 ☐ Suicide 6 ☐ Could not	be 28e. Plece of Ir	njury - At home, to	arm, street, tacto	ory, office	N. Control	28	t. Location (S	treet end Numi	ber or Run	el Route Number,
Te	4 Homicide	building, e	tc. (Specify)					City or Tow	n, Stete)		
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	30. Nema and address of person who	completed cause of	deeth (I)em 23a).	Type, Print)							
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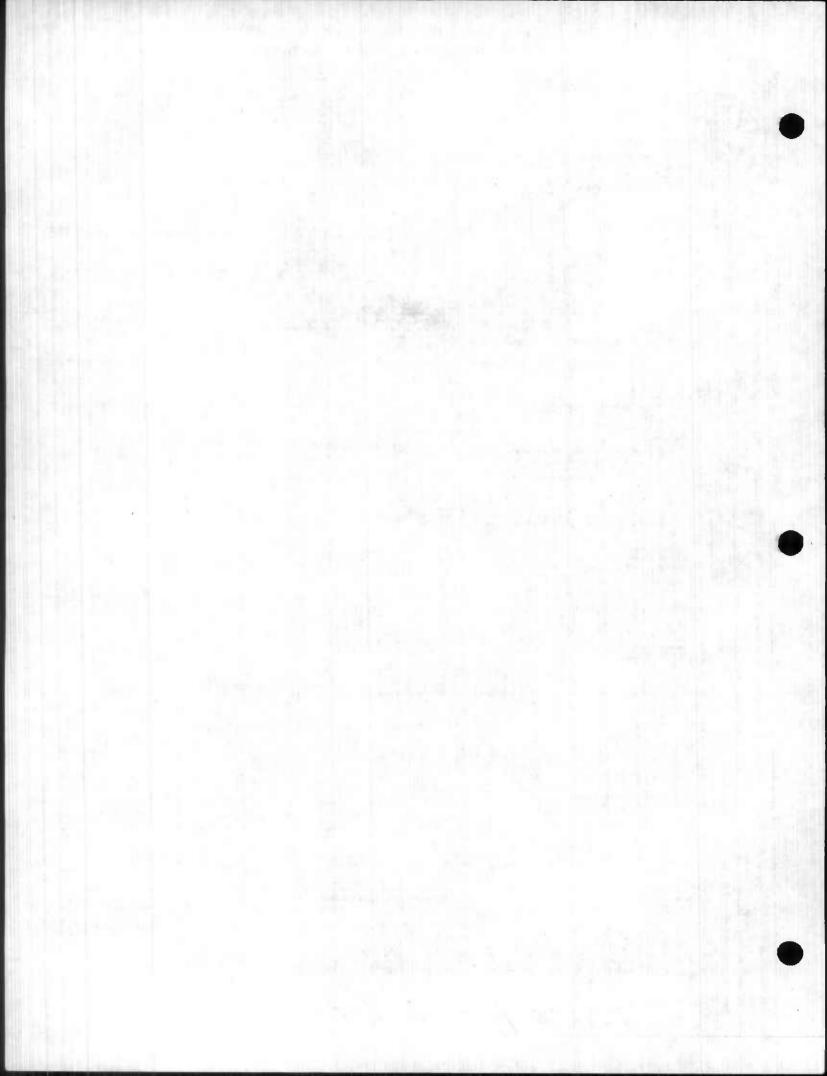


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28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Cocation (Street and Number or Hural Ho	ute Number,
29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Medical Examiner: On the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated and menner stated. 29e. Signature and title of certifier (Month, Dey, Check only one)	
29c. License number 29d. Dete signed (Month, Dey,	Year)
D52261 December 15,	2000
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Point) Dr. Alan R. Segal 1299 Lamberton Drive Silver Spring, MD 20902	
State Registrar State Registrar DFC 19 2000 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture Apartle B. Apartle	

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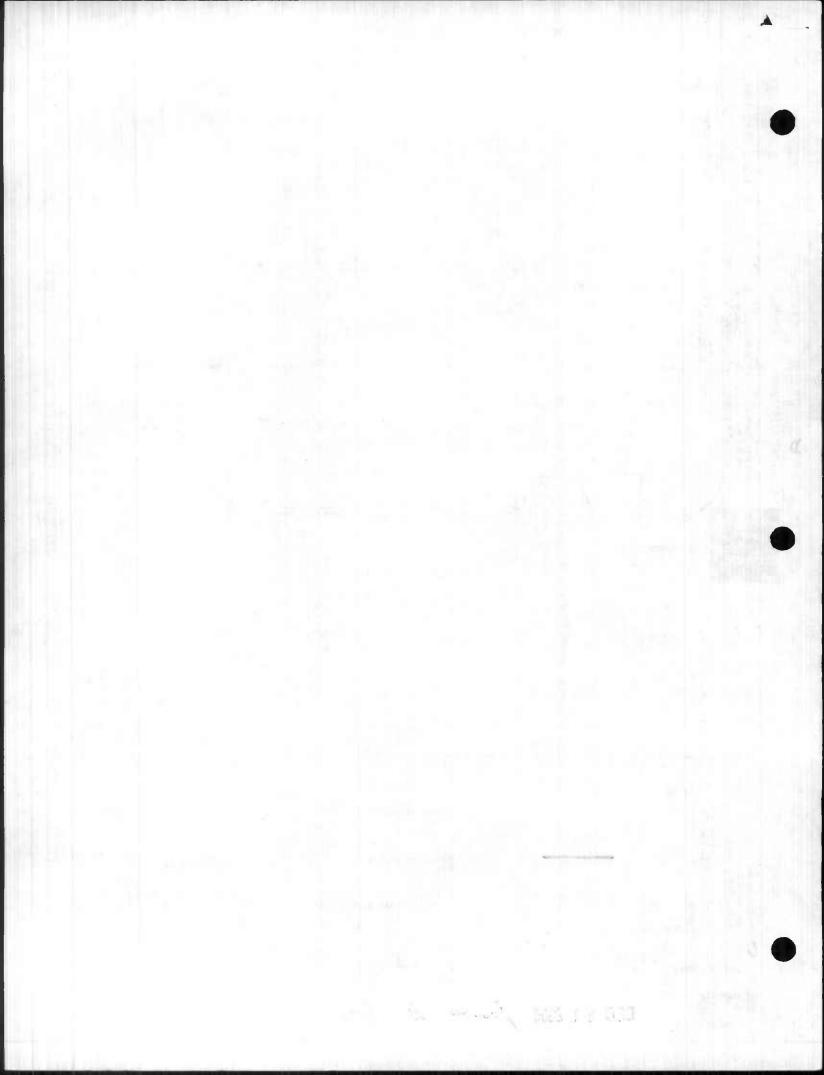


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Registrar

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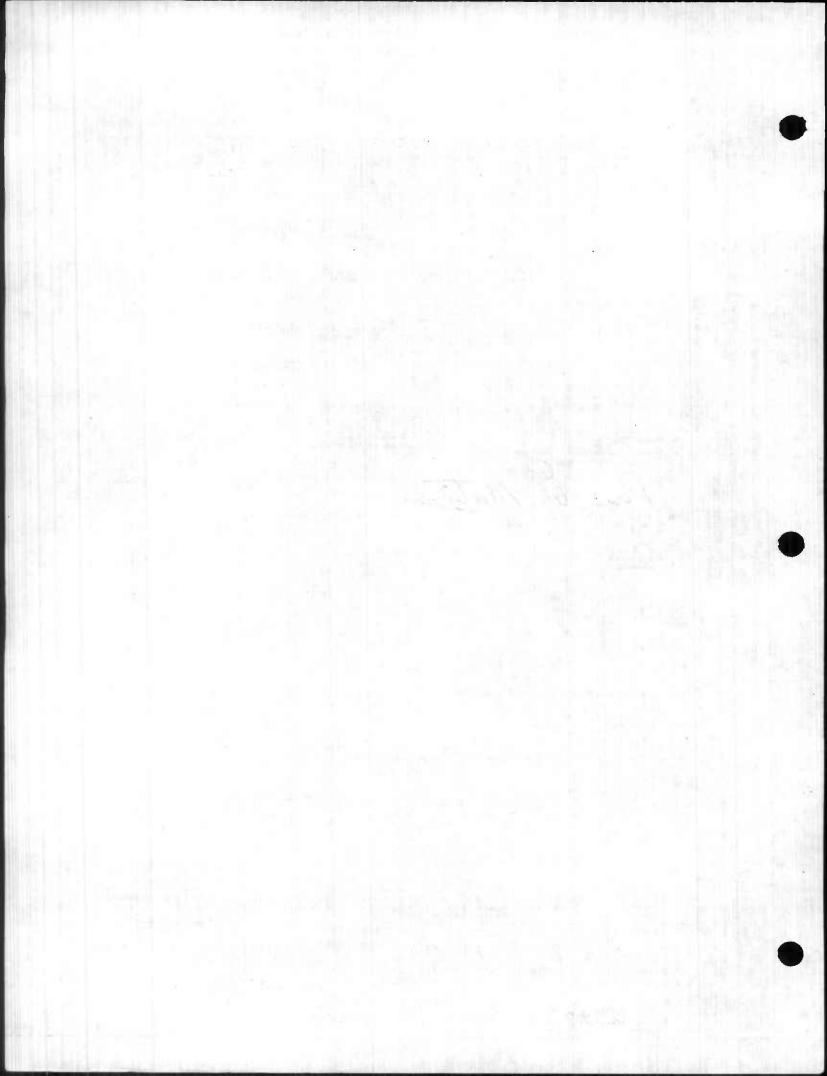
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State Registrar

31. Data filed (Month, Day, Year)
DEC 2 2 2000

30. Nema end address of person who completed cause of deeth (Item 23a) (Type, Print)

Robert L. Gold, MD 15225 Shady Grove Rd, #201, Rockville, Md. 20850 Sports



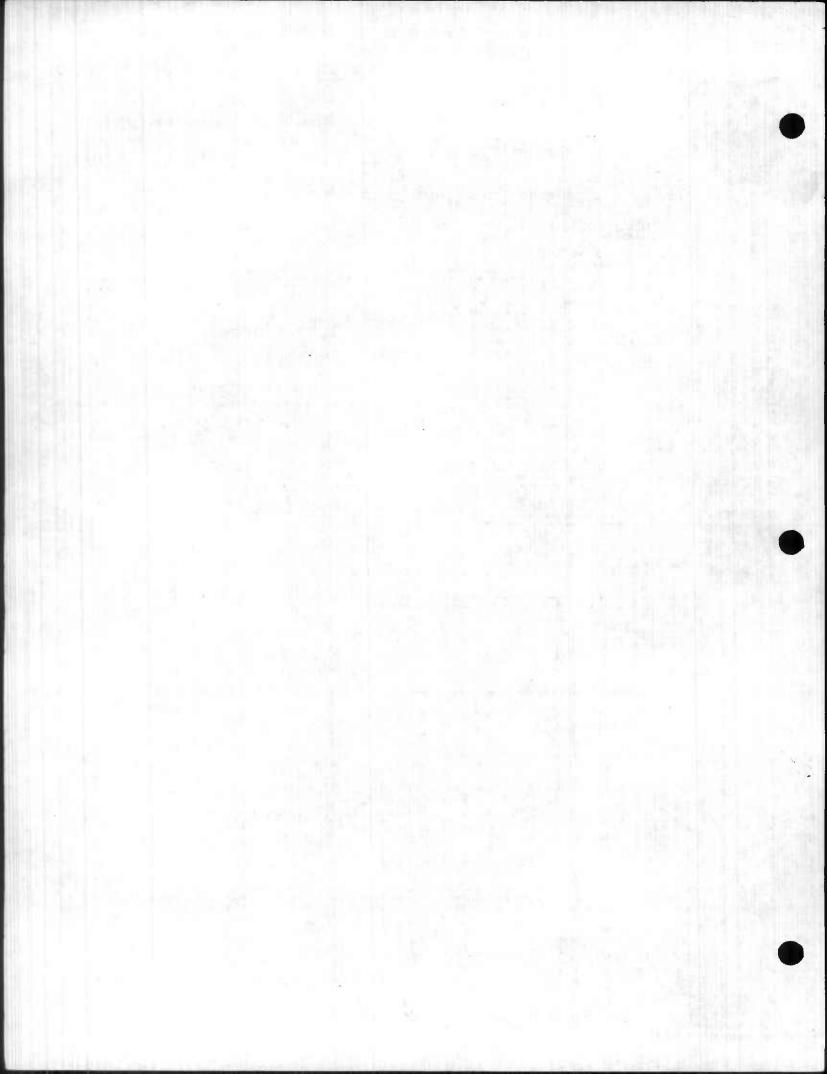
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	Maryland 21215-0036 d 2 should be filed within 72 hours after dee th and Mental Hygiene. T in marked other than "naturel", or items treumatic event, the Mental Eventre or	by Funeral		rried 2 Married	12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas:			If Yas, specify C		gin? (Specify Yas or N n, Puarto Rican, atc.)	Specia	white,	etc.		
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	should No man			Name/Ralationship ((Type, Print) 19			ling Addrass (Str			Rural Routa Number, City or Town, State, Zip Code)				
			Candi Ma	dgwick -	Sister		501	East Way	ne Ave	. Silver Sp	oring. M	ld. 20	901		
			20a. Method of Di				Data	20c. Location - City or Town, Stata							
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	Baltil Permit. P Departm Importar any Injur	BOUG	Hines-Rinaldi Funeral Home 11800 New Hampshire Av. Silver Spring, Md. 20904												
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	Box 68 sath certifical attending phy for use es th	Setached for use es the Physician/Med			d										
			Double Other of	Me	s contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death				
	O the chock	ls/r	Part II. Other sign	micant conditions o	contributing to death	DUT NOT FAS	suiting in tha	undanying cause	a givan in Part i				bebly 4 Unknow		
	That that dete	×) 108 220(NO	3 110	JEDIY 4 DINKHOW		
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	Signature deept	Cal	2 Accident 3 Suicida	6 ☐ Could not b							28f nesting /Street and Number or Dural Pouts Number				
	Division of Vital Records, P.O. or Attending Physician: The law requires that the dather destin. Director: After this certificate has been signed by the bine the tuneral director, page 2 should be detached in by the funeral director, page 2 should be detached.	Certification:	3 ☐ Suicida 4 ☐ Homicide 28a. Plece of Injury - At homa, farm, straet, factory, office building, etc. (Specify)						108	28f. Location (Street and Number or Rurel Routa Number, City or Town, Steta)					
	Division of Vita within 44 bus steed each a steed each to the Hoppital or Attending Physician. Within 44 hours alse deem, After this certifical completely filled in by the funeral director,	edical Co	29a. Certifier (Check only		niner: On the basis	of axamina				nd place, and dua to the					
	the the	Med	one)	d title of contilies	and manner	stated.		200 130	ansa number		29d. Data sign	ed (Month	Dev. Year)		
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			Ati	NIA	Vlac	M	MIK		D.C.M.E	•	Dece	mber	20, 2000		
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State Registrar

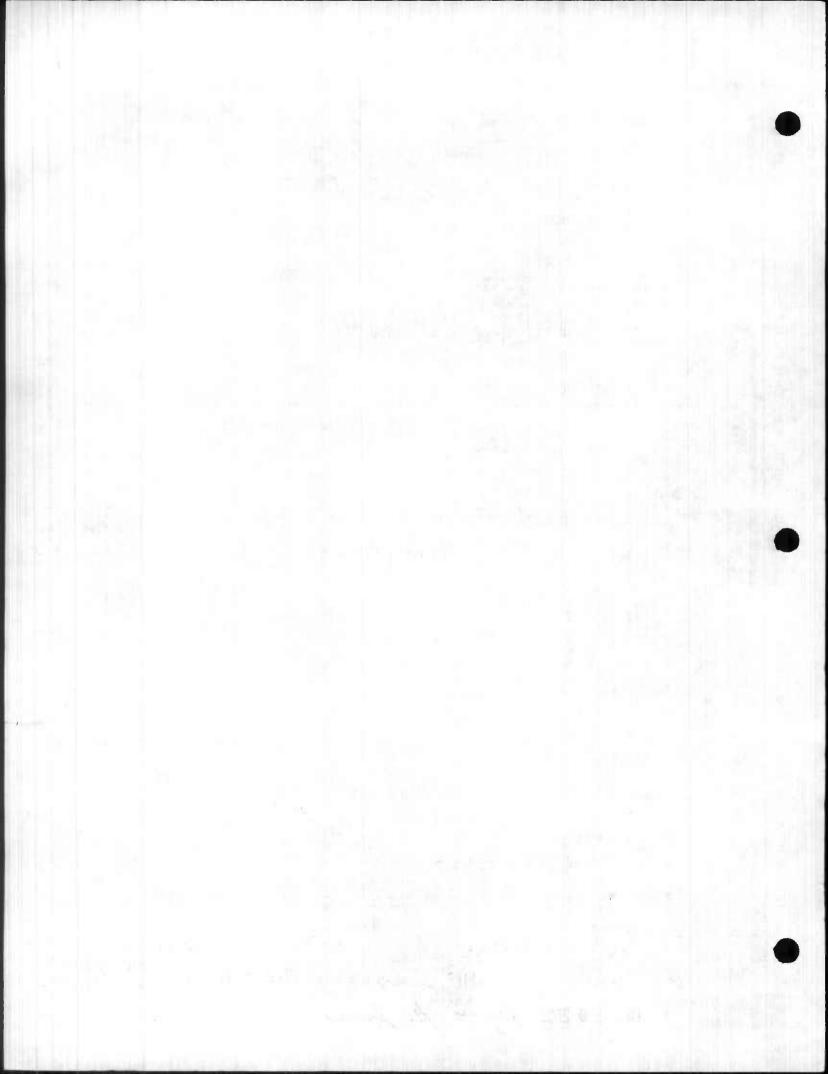
Stephen S. Radentz, 11
31. Data filed (Month, Day, Year)
DEC 2 2 2000
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	1. Decedent's Name (First, M.	iddle, Las	st)							2. Deta of D Month	Reg. No.		Year	3. Tima of De
in al	Savitri Madan										December 16, 2000 2:30am			
aı er									wn, or Lo	or Location of Death 4c. County of Death				
	7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								er Spring Montgomery					
ŀ	5. Social Security Number	6. S	өх	7. Age (In yr	s. last birthday	y) If Unc	der 1 Year	If Under	-	8 Data of B	Rirth 9 Rirthplace (State or Fo			
	145-82-5650	1	□ M 2 🔭 F		81 Yrs.	Month	ns Days	Hours	Min.	(Month, D	ay, Year) 6, 191		Count India	
	Usual Residence of Decedent			t		1.	1	1		Uall 2	0, 101		LIIGI	
ĺ	10a. Stata 10b. Cou	inty		10c. 0	City, Town or I	Location	-37			-			10	d. Inside City L
	MD Man	+			. 1	C								1 Yes 2
MD Montgomery Silver Spring 106. Street and Number 107. Zio Code														
			10f. Zip Coda						10g. Citizen of What Country?					
	14556 Pebblestone Dr.						0905				Indi	a		
ı	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent It Yas, specify (cedent of hospity Cub	lispanic Ori	gin? (Spe	ecify Yas or N Rican, atc.)	0- 14		 Amarica Whita, a 	an Indian, itc.		
	1 Never Married 2 N	Aarried	1 Yes	1 ☐ Yes 2 ☐ No			2 2 No							
	3 ☑ Widowed 4 ☐ Divor	ced					265140	эрвину.				<i>pecify:</i> Ind:	ian	
	15. Decedent's Edu		lucation		16a. Dec	edent's U	sual Occup	oation	A = 4 . cm = 1.		16b. Kind	of Bus	iness/Ind	ustry
	(Specify only highest grade Elementary/Secondary (0-12)				lifa.	DO NOT	work dona use ratire	during mos d)	t or worki	ng	Own	Hom	e	
	Elementary/Secondary (0-1	College	College (1-4or 5+) 2 Homema			r								
	17. Father's Name (First, Midd	fle, Last)						18. Moths	ar's Nama	(First, Middle	e, Maiden St	umama)	
Mathura Das Pahwa										a Dev				
					40. 1		45		- 4		-			0.11
	19a. Informant's Name/Relati		ype, Print)											
1	Rajiv Madan /	/Son		14556 Pebbleston					Dr.,	Silve				
ĺ	20a. Method of Disposition				. Place of Disp cematary, cri	position (A	Vama of or other pla	ce)	1,	Data Dec 18	20c. Loca	ition - C	ity or To	wn, State
	1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other				Chesape					2000	Belt	svi	lle,	MD
	21. Signature of Funeral Serv			1				ass of Facilit		2000		-		
l	12 11	0	7/ //	11		Rapp	Fun	eral	& Cr	emation				
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l	arroad or mount round of	Dot oing	hplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, y one cause on each line.								errast,		1	Interval Ratwee
ı									carolace	и газрнаюту	errast,			tntarval Batwee Onset and Daa
l	Immediate Cause (Finel								Car Glac C	or raspiratory	errast,			Interval Batwee Onset and Daa
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Res No 0 4 2 | 98

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Physician /Medical	Decedent'a Name (First, Middle, Las CARL ADRIAN McC							Dete of Dee Month CEMBER		Year	ime of Death 49 AM		
Examiner	4e Facility Neme (If not institution, give RT 51 OLDTOWN ROA	PROPERTY AND ADDRESS OF THE PARTY OF THE PAR	PERSONA	I CARI			wn, or Locat CUMBER	ion of Deeth LAND	4c. County	of Deeth EGANY			
Funeral Director	231 10 0337 11 1	9x 7. Age (Ir →M 2□ F 68	yrs. last birthday) Yrs.		Year Deys	If Under a	24 Hrs. 8. Min. JA	Dete of Birth (Month, Day N 24	332	9. Birthplace (Country) W . VA .	Stete or Foreign		
the Maryland 28a-f show notified at	Usuel Residence of Decedent 10e. Stete 10b. County FLORIDA BROWARD	10	c. City, Town or Lo								10d. Inside City Limits		
Sa or 28a-fi at be notifie at Directo	1 10e. Street and Number 10f. 2lp Code								10g. Citizen of What Country? U.S.A.				
hours after doat ural; or liems 2 at Examiner mu d by Funers	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? ***LaYes 2 _No if Yes, Give Yeer or Dates 1 9 5		Was Decede if Yes, specif				Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE				
ad within 72 ho ygiens. ser than "naturn s, the Medical I	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 12 16a. Decedent's Usuel Occupation (Give kind of work done during most of working) (Give kind of work done during most of working) (Bive kind of work done during most of working) (Bive kind of work done during most of working) (Give kind of work done during most of working) (Bive kind of work done during most of working) (Bive kind of work done during most of working) (Bive kind of work done during most of working) (Bive kind of work done during most of working) (Bive kind of work done during most of working) (Bive kind of work done during most of working) (Bive kind of work done during most of working)							A.C.	16b. Kind of Business/Industry REFRIGERATION & A.C.				
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and 2 sh sellh and n 27 is m er traum	196. Informent's Neme/Reletionship (Type, Print) 'ADRIANNE THOMPSON DAUGHTER 195. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 13321 MASON ROAD N.E. CUMBERLAND MARYLAND 21502												
Pages 1: ment of He ant: If Nem uny or oth	20a. Method of Disposition XXBuriel 2 Cremetion 3 Removel from State 4 Donetlon 5 Other (Specify) Communication Detection Other (Specify)												
permit. Departiment import any inj	21 Signature of Funeral Service Licen	see	M	ERRIT	T-AD	AMS I	FUNERA		E P.A.	DV: AND			
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aw requir								24a. Wes e	en eutopsy med?	eveilable	on of cause		
	25. Wes case referred to medical					26 Place	of Dooth //	1 D Y	21	1 🗆 Yes	2 No		
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or Attending of Attending of the fune in by the fune stiffication	27. Menner of Deeth 1 Neturel 5 Pending 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 2 Accident 3 Suicide 4 Homicide 4 Homicide 28e. Plece of Injury - At home, ferm, street, fectory, office 28f. Location (Stree City or Town, Street)									care Home treet end Number or Rural Route Number,			
within 24 hours within 24 hours of To the Funeral Completely filled		rsician: To the best of m Insr: On the basis of exa end menner steted									euse(s)		
1/2	29b. Signeture end title of coording	29d. Date signed (Month, Day, Year) DECEMBER 14 2000											
per Winder hadion Jus	30. Name and address of person who of DR URIEL E. VELAI 31. Date filed (Month), Day, Year 000		ETON DRIV		MBER	RLAND	MARYI	AND	21502				

DEC 1 - MADE SOLD SEEDS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Vear **Physician** Lillian Mvers 20, 2000 18:35 December /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Cumberland Alley
If Under 24 Hrs. B. Date of Birth
Hours Min. Oct 17, 1920 **Allegany** Memorial Hospital & Medical Center If Under 1 Year Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M X 0 F Months Deys Yrs. 80 220-10-8556 Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow ? is marked other than "natural", or Name 23a or 28a-f abov traumatic avant, the Medical Franchise must be notified as 1√2 Yes 2 □ No Director Cumberland Allegany MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 235 Paca Street Apt 503 deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Stetus Bleck, White, etc. 72 hours after 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1□ Yes 2□ No Specify Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Heelih and Mental Hyglene. Important: if item 27 is marked other than "natu page. 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondary (0-12) orchard 12 laborer 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) (Lowther) Charlotte Carl Henry Schade 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 235 Paca St Apt. 503; Cumberland MD 21502 Russell D. Myers Shared of Bisposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 12/23 N☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Memorial Park Cumberland, MD Sunset 21. Signeture of Funeral Service Licensee Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Renal Failure Examiner Due to (or as a consequence of): Physician/Medical Examiner Acute Tubular Necrosis attending physicien and for use as the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760 Sepsis Due to (or as e consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Tyes 2 No 3 Probably 4 Unknown History of CVA, Senile Dementia by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? should I 24a. Wes en eutopsy performed? Completed page 2 s 1 ☐ Yes 2 DENO 1 ☐ Yes 2 ☐ No After this certificate To the Hospital or Attanding Physician: within 24 hours after deeth.

To the Funeral Diractor: After this certifics completely filled in by the funeral director; 25. Was cese referred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury et Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. edicai 29a, Cartifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number KUN 1/har My December D19318 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6

State

DEC 2 1 2000 Registrar

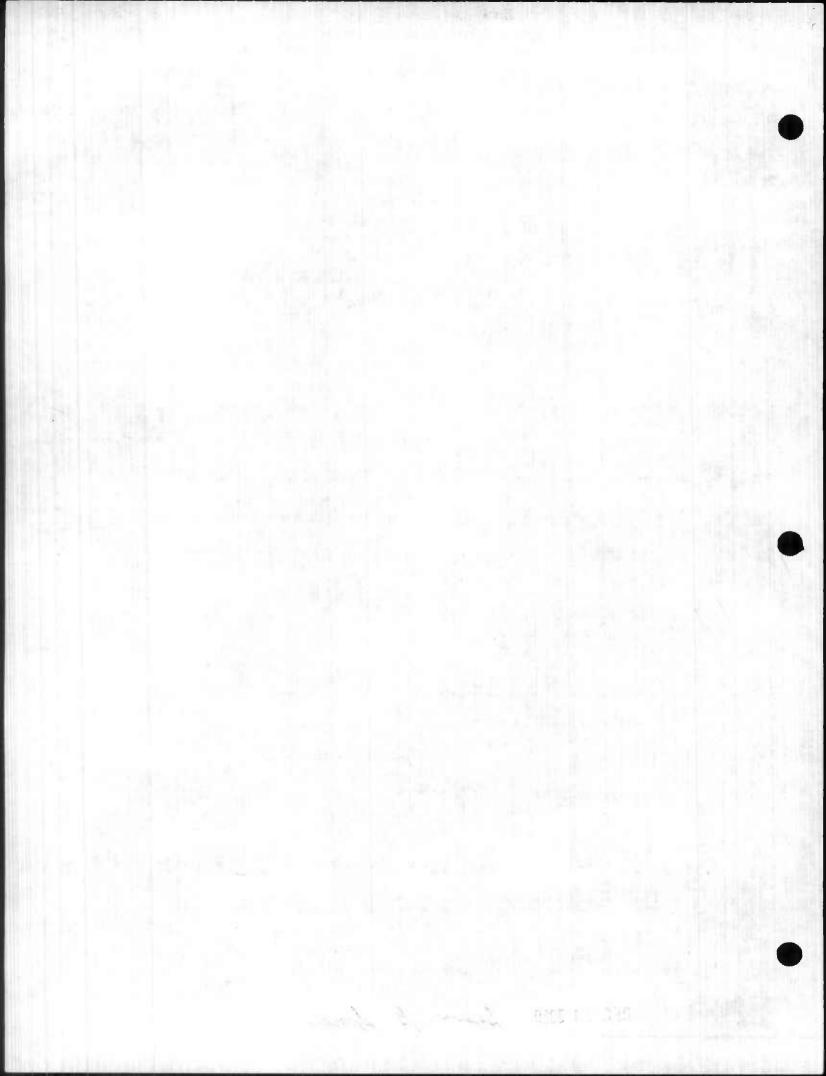
N. 31. Dete filed (Month, Day, Year)

A. Ranjithan

517 Oldtown Road 32. Registrar's Signature

Cumberland, MD

21502



d / Department of Health and Me	ntal Hygiene [L	2	2	1
Certificate of Death		-6	-	han	0
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nar	les Wil	lia	am Meyers	State of	f Marylar		artment <i>rtificate</i>			nd M	lental Hy	giene (1 42	2200
		_	1. Decedent's Name (First, Middle, Last)		Ta Alle			1		2. Dete of De	eth	Vans	3. Time of Death
	Physiciar /Medica		CHARLES WILLIAM I	NEYERS							Month Decemb	er 23,	2000	12:17 A.M.
	Examine	- 17	la Fecility Name (If not institution, give		nber)			4			ocation of Deat	h 4c. Co	unty of Deeth	1
			Memorial Hospi				I Williadaa d	4 Vana	Cumb				Allega	-
	Funeral Director		5. Social Security Number 6. Se 211 36 3863	X M 2□F	7. Age (In yrs. 43	lest birthday) Yrs.	Months	Deys	If Under 2 Hours	Min.	8. Dete of Bir (Month, De 3 → 1 → 1 9 5	th by, Year) 7	9. Birth Cou MD	place (Stete or Foreign intry)
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	ath with the Marylar 23s or 28s-f show	5	100. Street and Number 130 Cleveland St	reet			10f. Zip 0	Code 5 4 5				10g. Citizen USA	of Whet Cou	intry?
036	urs after de al', or herre	Dy rur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed Fo XXYes If Yes, Giv Year or De	2 No 1985		Was Decede If Yes, speci	fy Cuba	spenic Orig n, Mexican, Specify:	in? (Sp Puerto	ecify Yes or No Rican, etc.)		Race - Amer Bleck, White ecify: W	
Maryland 21215-0036	within ane.	Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	cation e completed) College (1	-4or 5+)	(Give	dent's Usuel kind of work DO NOT use	k done d e retired	fu <i>ring</i> most)	of work	ing		of Business/le	ndustry
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	and Beelth m 27 her tr		Harold W. Meyers	, fathe						et,	Hyndma		15545	
Baltimore,	Pages 1 nent of H int: If Ite	1	20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☑ F	lemovel from	Siele	Placa of Disponentery, cre			a)	i	Date		ion - City or T	
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of Vital Records,	aw requires s been sign 2 should be							2	4			en eutopsy ormed?	8	Were eutopsy tindings available prior to completion of cause of death?
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Division		Certifica	3 Suicide 6 Could not be determined	28e. Pleca buildii	of Injury - At h	iome, ferm, st	reet, fectory,	, office			28f. Location (City or To	Street end N wn, Stete)	lumber or Ru	PISUSISY W
	Hospi 4 hour Funer tely fill	adicai	29a. Certifier 1 Certifying Phy: (Check only one) 1 Amedical Exami	ner: On the be	best of my kno	owledge, deet	vestigation,	in my o	pinion, deat	d plece, h occur	end due to the	cause(s) en date end ple	d manner es eca, end due	stated. to the cause(s)
	To the within 2 To the comple	2	29b. Signature and title of certifier Menute	The	Shill		29c.		c.M.F	Ξ.			nber 2	4, 2000
	C	1	30. Neme and address of person who or	moleted caus	e of deeth (tree	m 23a) (Type.	Print)							

31. Dete filed (Month, Dey, Year)
DEC 2 6 2000

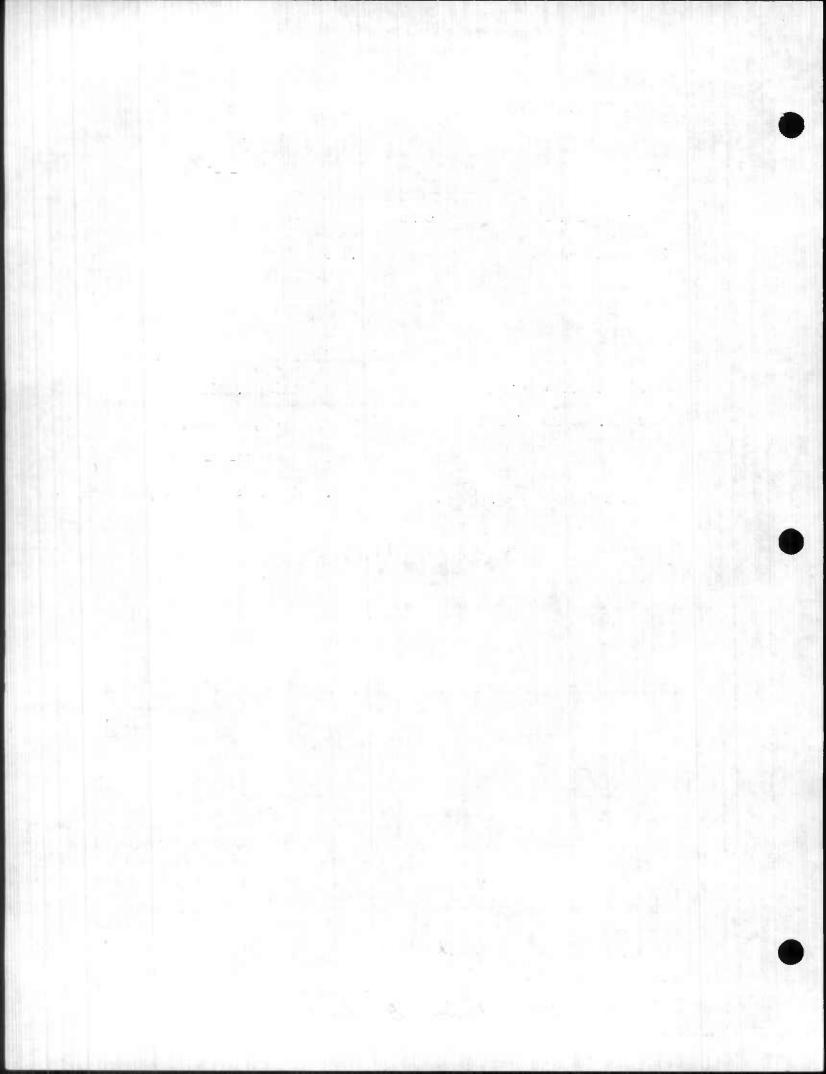
32. Registrar's

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signeture

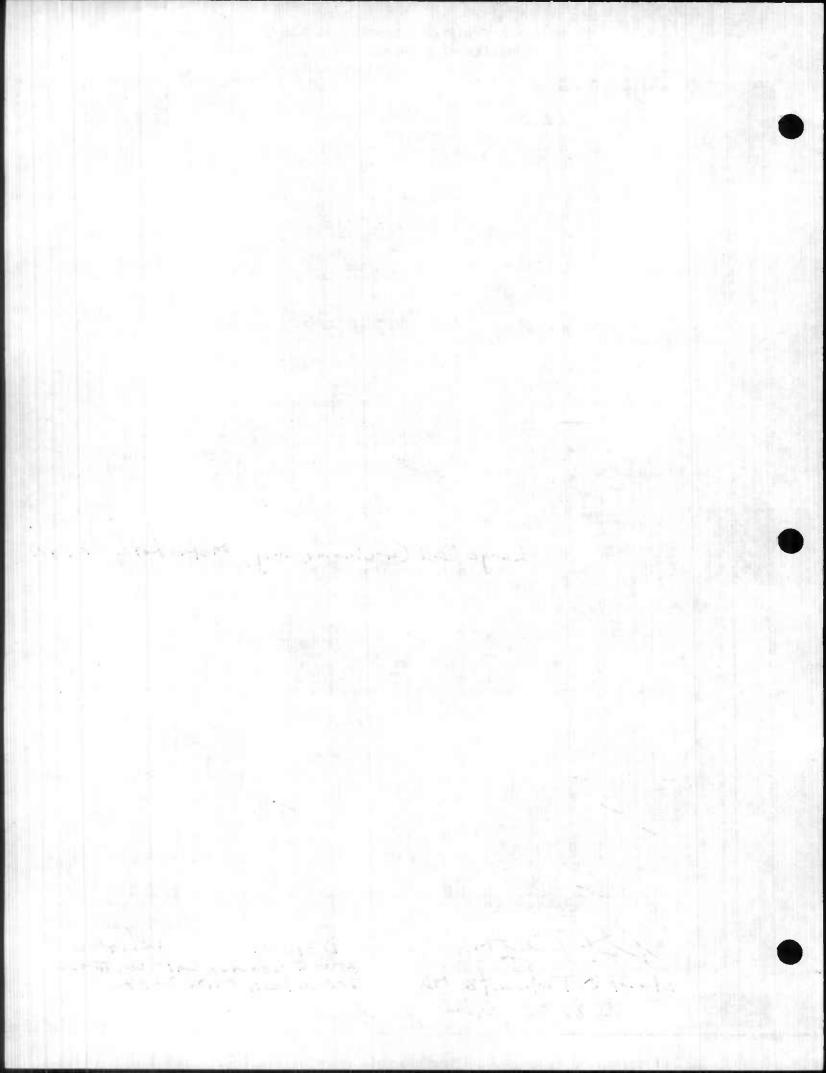
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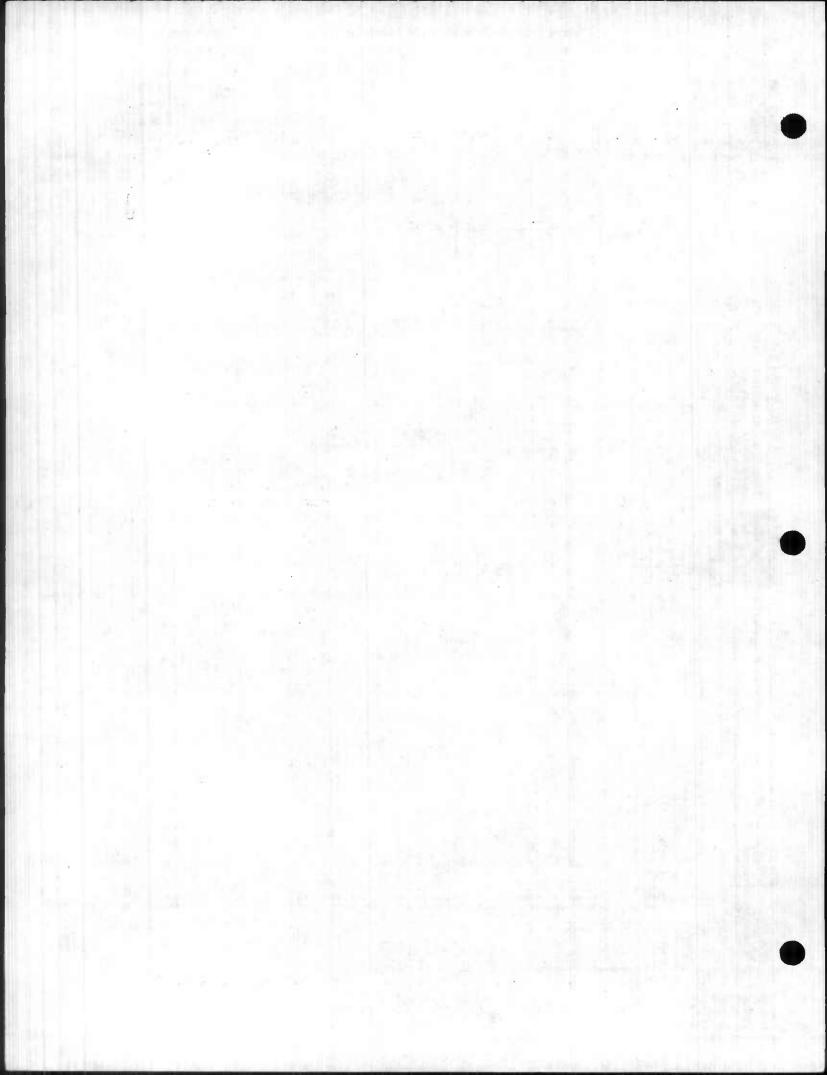
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uneral Director	5. Social Security Number 214-41-5263	Sex 7. A 1 ☐ M 2 🖾 F	ge (In yrs. la 84	ast birthday) Yrs.	If Under 1 Year Months Deys			th y, Year) 1916	9. Birthp Coun Vieti	lece (State or Fore stry)
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or 28a-f show be nothing at Director		merv		ilver						1 ☐ Yes 2 🔯
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	Examiner	4a Facility Neme (If not institution, given WASHINGTON ADVEN			E.R.		4b. City, To		ARK	,	of Death	7	
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1	>	30. Neme end eddress of person who	completed cause of										-10
		JACK M. TIT	45, M.D.	11	ll Penn	Stree	et, Balt	imor	e, Mary	land 21	201		
	State Registrar	31. Dete filed (Month, Dey, Year) DEC 18	2000 32. R/gi	strer's Signe	g.	ppa	Ke						

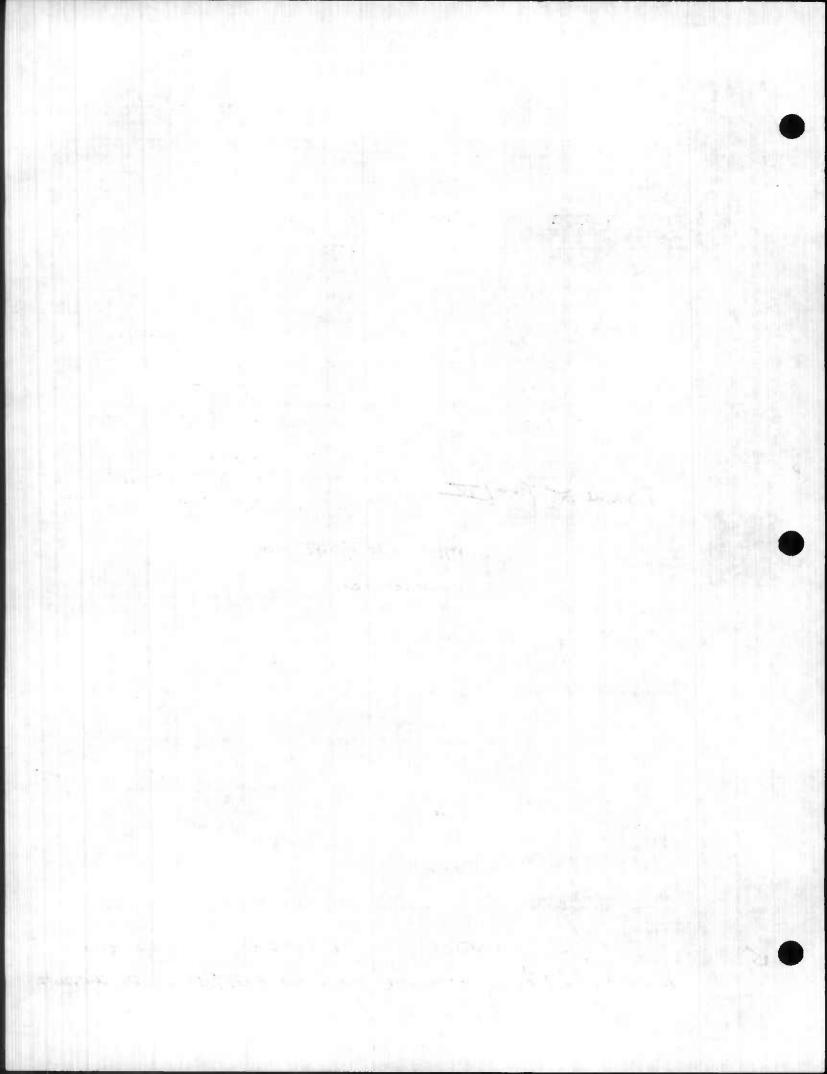


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** AMOS ORANGE 12 18 2000 1:46 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL
5. Social Security Number 6. Sex 7. Age PRINCE GOERGES If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 1 € M 2 □ F 54 230-62-8836 Director VIRGINIA Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumstic avent, the Medical Express must be notified at Yes 2□No Director PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17103 FAIRWAY VIEW LANE 20772 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Baca - American Indian. Black, White, etc. 1 Yes ON No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) DELIVERY FEDERAL EXPRESS COURTER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RAYMOND ORANGE SR. CATHERINE WHITE ORANGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6001 Rose Bay Drive, Forestville, MD 20747 ANDRE T. ORANGE / SON 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12/21/00 Wash. D. C. _1 Burial 2 □ Cremation 3 □ Removal from State Glenwood Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility James E. Vann Funeral Home, Inc. 21. Signature of Funeral Service Licensee Inne 20011 4804 Ga. Ave. N. W. Washington, D. C. 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** ASTHMATICUS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) HYPER TENSION Examiner attending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s has 1 Yes 2 No 1 TYPS 2 TO NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 → ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending Privinin 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **4** ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 035947 12-19-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Norman G. Mckey 10274 cont on Bon asyt 202 Mitchellille (MD-2072) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 21 2000 Registra

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ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Month Day Year **Physician** Mary A. O'Connor December 10, 2000 10:55AM /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner #811 Chevy Chase
If Under 24 Hrs. 8. Do
Hours Min. (A 8100 Connecticut Avenue, Montgomery 8. Data of Birth (Month, Day, Year) May 20, 19 If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 6. Sex **Funeral** Deys 1□ M 2♥ F Months 87 1913 011-38-7462 Director Massachusetts Usual Rasidenca of Decedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Example: must be notified at 1X Yas 2 □ No Directo Maryland Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue, #811 8100 Connecticut 20815 United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forcas?

1 Yas, 2 No If Yas, Giva Yaar or Datas: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Bleck, Whita, atc. 72 hours efter 1 □ Nevar Married 2 □ Merried 1 Yas 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. other than Elemantery/Secondery (0-12) College (1-4or 5+) 5+ permit. Pages 1 and 2 should be filled v Department of Heelth and Mental Hygle Important: If Itam 27 is marked other th any injury or other traumatic avent, the once. Homemaker Own Home 18. Mothar's Nama (First, Middle, Maiden Surneme) 17. Father's Nama (First, Middla, Last) Be Parker Shannon Mary Kilderry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 50 Clubhouse Road, Key Largo, Florida 33037 Shannon A. Fairbanks/Daughter 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition Data 1 Buriel 2 □ Cramation 3 □ Ramoval from Stata Dec 16 2000 4 ☐ Donation 5 ☐ Othar (Specify) Newton Cemetery Newton, Massachusetts 21. Signature of Fundral Sarvice Licans 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 7557 Wisconsin Avenue M00803 Bethesda, Maryland 20814 Terry 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvel Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Arrythmia Examiner Due to (or as a consaquance of): Examiner Anemia attending physicien and for use as the bunal-transit The lew requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiate cause. Entar Underlying Causa (Disease or injury Dua to (or es a consequança of): Physician/Medical that initiated avants rasulting in death) Last Dua to (or as a consequance of): detached Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings aveilabla prior to complation of cause of death? 24a. Was an autopsy Completed After this certificate hes 96ed 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No funarei director, 25. Was case referred to medical Be 26. Plece of Deeth (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nesidanca 6 □Othar (Specify) 2 1 X Yas 2 □ No 28b. Tima of 27. Menner of Deeth 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 3 ☐ Suicida 6 ☐ Could not be datarmined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homloida within 24 hours a To the Funeral C completely filled 12 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data and place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the ceuse(s) and mannar steted. 29a. Certifiar edica (Check only one)

P.O. Division of Vital Records, Physician: potal or Attanding Products after deeth. Hospital

To the

Baltimore,

Box 68760

State Registra

31. Data filed (Month, Day, Year) DEC 1.9 ZUUU

David W. Patterson,

29b. Signatura and titla of certifian

32. Registrar's Signatura There

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print)

M.D.

2440 M Street, N.W., #817, Washington, D.C. souls

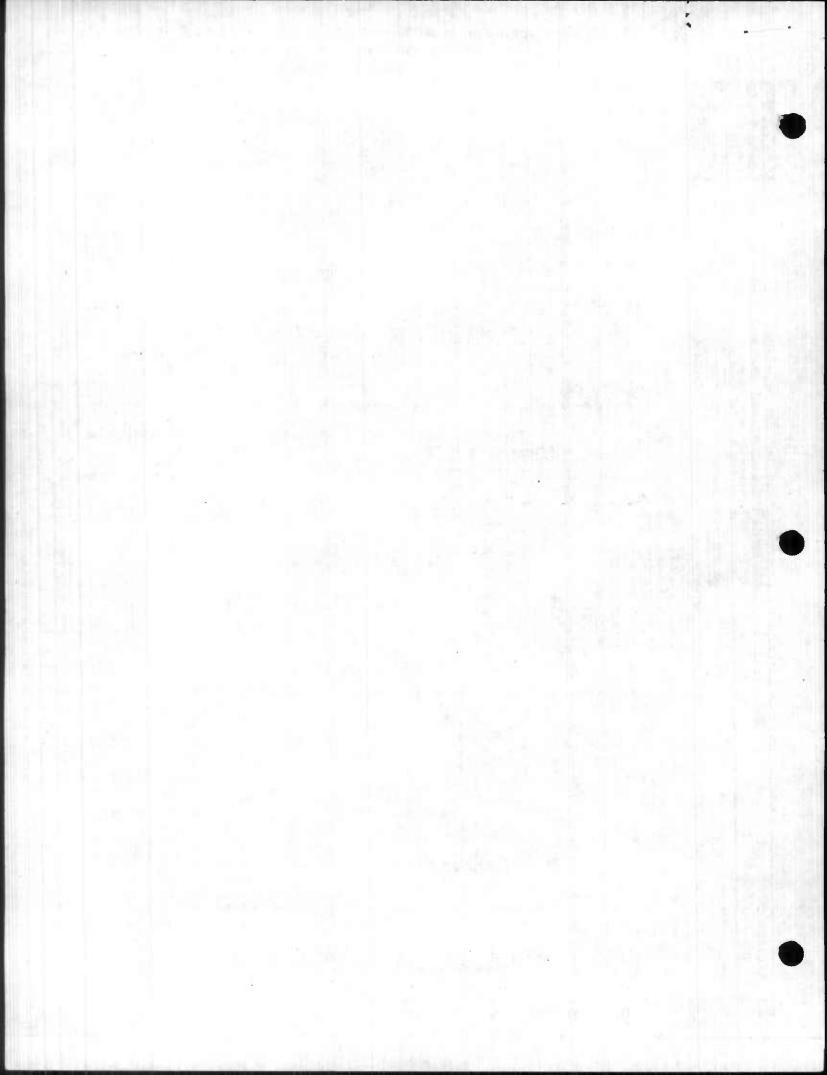
29c. Licansa number

16443

29d. Data signad (Month, Day, Year)

December 18, 2000

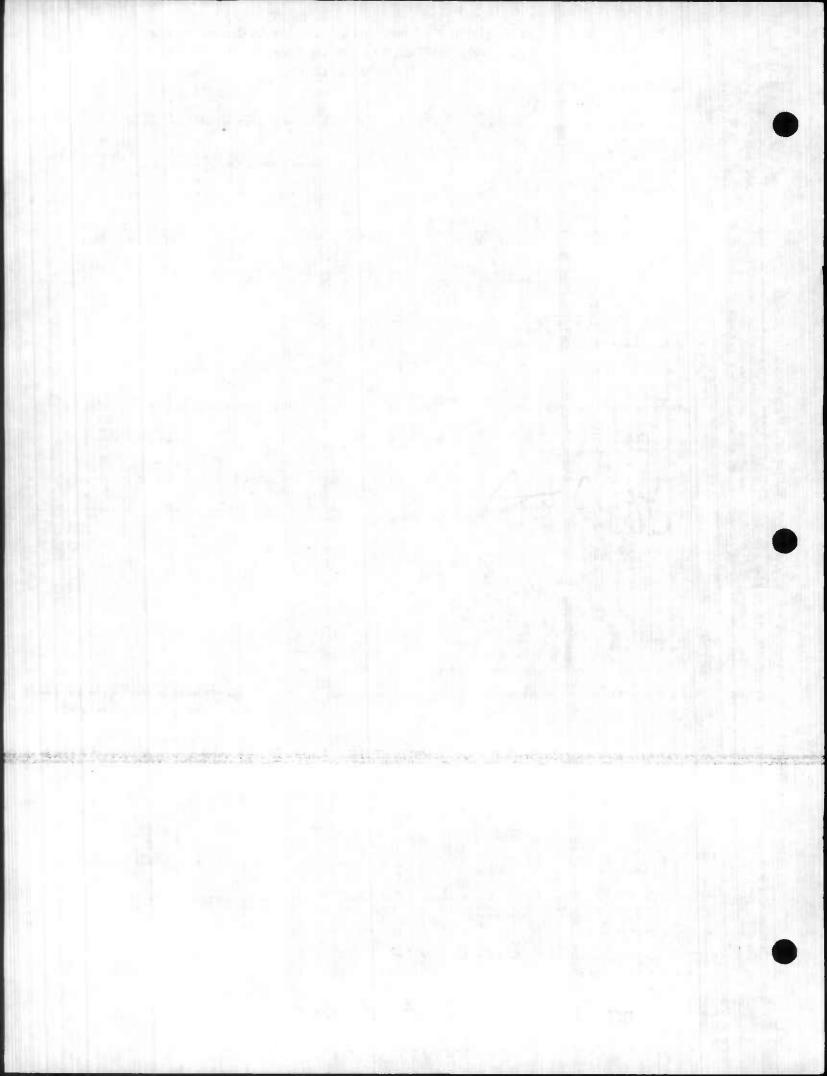
20037-1404



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						Certin	ficate o	f Death		R	eg. No.		
5	1. Deceder	nt's Name (First, Middl	e, Last)							Date of Dea Month		Voor	3. Time of Death
Physician /Medical	Char	les Robert	Powel1						D	Month ecembe	r 14,	2000	7:50 PM
Examiner	4a Facility	Name (If not institution	n, give street ar	nd number)				4b. City, Tow	m, or Local	ion of Death	4c. Cour	nty of Death	
	Case	y House-Mo	ntgomer	y Hospi	ice			Rockv	ille		Mont	gomer	у
uneral	5. Social S	ecurity Number	6. Sex	7	n yrs. last b	N/	f Under 1 Yea		4 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Birth	piace (State or Fore
irector		50-1487	1 🔀 M 2	JF	61	Yrs.				ec. 19,			ington, D.
*	Usuai Resi 10a, State	dence of Decedent 10b. County		11	oc City To	wn or Locat	ion						10d. inside City Limi
ust be notified at rai Director												20.29	1⊠ Yes 2□N
be notified Director	Maryl	and Montg	omery	K	lockv		tot 75- Code				Og. Citizen o	4 Martines Cour	
D P							10f. Zip Code						
iner must Funeral		Duke Stree		s Decedent Eve	r in H C	12 Way	208		in? (Connié	v Voc or No-	United States 14. Race - American Indian		
Fun	11. Maritai	Status ver Married 2⊠ Marr	Arm	ed Forces? Yes 2 No	1957-	if Ye	es, specify Cu	f Hispanic Origi Iban, Mexican,	Puerto Ric	an, etc.)		lack, White,	
ò		dowed 4 Divorced	If Ye		963	10	Yes 2₩ N	o Specify:			Spec	ify: W	hite
			it's Education		16	a. Deceden	t's Usuai Occ	upation			16b. Kind of	Business/In	ndustry
Completed	Florida	(Specify only higher	st grade compli			(Give kindlife. DO	d of work dor NOT use reti	ne during most (of working				elligence
Eo	Element	ary/Secondary (0-12)	Colli	ege (1-4or 5+) 4	5	Securi	ty Mar	ager				gency	0
	17. Father's	s Name (First, Middle,	Last)	10.00					's Name (F	First, Middle,	Maiden Sum	ame)	
To Be	Char	les D. Pow	e11					Beula	ah Jo	nes			
-	19a. Inform	nant's Neme/Relations	ship (Type, Prin	nt)	15	9b. Mailing A	Address (Stre	et and Number	or Rural F	Poute Number	r, City or Tow	m, State, Zi	p Code)
5	Leono	re G. Powe	11/ Wi	fe	81	l6 Duk	e Stre	et, Roc	ckvil	le. Ma	rvland	2085	0
60	20a. Metho	od of Disposition	TO THE	1	20b. Place	of Dispositio	on (Name of ony or other p			Date	20c. Locatio		
5	1 □ Bt	urial 2 ☑ Cremation conation 5 ☐ Other (S	3 □Removai					um, Inc.		ember 2000	Rethes	da M	aryland
		ure of Funeral Service	Control of the last of the las		. wirego	22. N	ame and Add	lress of Facility	Robe	rt A.	Pumphr	ev Fu	neral Hom
9	1	M	71	1006	90	Beth	esda-(hevy Ch	nase,	Inc.	7557 W	liscon	sin Avenu
	23a. Part1	VIII STORES	complications					, Mary					Approximate
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ian ical	Immediate	Cause (Final	M		. 4 - W	1							0
ner	disease or resulting in	condition	a	etastat							+	One year	
e e	187.1		М	ialignan		a consequer							3½ years
edical Examiner			b			a consequer	_	-	-			-	J ₂ years
Exa	if any, ieed	ling to immediate	110		0 10 (01 80 1	a consequen	1100 017.						
edical	Ceuse (Dis	ily list conditions, ding to immediate ster Underlying sease or injury ad events	c	Due	to (or as a	consequer	nce of):						
	resulting in	death) Last	TOTAL									i	
ician/Med			d									1	
leted by Physician/N	Part II. Oth	er significant condition	ons contributing	to death but n	ot resulting	in the unde	eriving cause	given in Part i.		23b. Did to	obacco uae	contribute t	to the cause of dear
Physician/M													obably 4 Unknown
by P	1												
2	-									24a. Was a			Vere autopsy finding vailable prior to
Completed									_	perior	megr	0	ompletion of cause f death?
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, O	25 Was ca	ase referred to medica	1					26 Place	of Dooth //	Check only or			2.00
ral director, page : To Be Com	examin	er? s 25 No	Hospitel:	1 Inpatient	2 □ E D //	Sutpationt	3D DOA	When				Wher /Snec	ity) Hospice
	27. Manner		28a.	Dete of injury	28b	. Time of	28c. In	4 🗆 1401:		d. Describe h			W HOSPICE
to o	1 ☑Na 2 ☐ Ac			(Month, Dey Ye	9ar)	injury		/ork? □Yes 2□N	lo				
led in by the tuneri Certification:	3 □ Su	icide 6 Couid	ined 200.	Piece of injury	- At home,	farm, street	, factory, offic	a	28	Location (S	treet and Nu	m <i>ber</i> or Rui	ral Route Number,
ert	4 □ Ho	omicide .	0.0	building, etc. (8	Specify)					City or Tow	n, Stete)		
ie C	29a. Certifi			To the best of m									
completely filled in by the funeral Medical Certification:	(Checi	k only 2 Medical	Examiner: On and	the basis of exa menner stated	amination a	and/or inves	tigation, in my	opinion, death	n occurred	et the time, d	late end piec	a, and due	to the cause(s)
N	29b. Signa	ture and title of cartifie	r				29c. Lice	nse number		2	29d. Date sig	ned (Month	, Day, Year)
		£ (P. 7	Cile	,	MD	D09	470			Decemb	er 15	, 2000
	30 Name s	and address of person			٠,	(Type Pri	nt)						
	1000	e P. Libre						0 V	19	on M.	1 - 1	2000	5
State		ed (Month, Day, Year)		32. Registrar's		/			TIIRL	on, na	тутано	2009	9
State		DEC 1 0			11	19.	Loon	21					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 1/2000, BMW, Montg. Co. Certificate of Death Reg. No. 2 Detect Death

Unuoio		1. Decedent's Name (First, Midd		g. Co.	-0.0	rtificate of		2. Dete of Dea	Reg. No. ath Dey	Year	3. Time of Deeth
Physicia /Medic Examin	al	GERTRUDE 4a Facility Name (If not institution			PENDERG		4b. City, Town, or	DEC. 1	3, 200	0	1:10 PM
		17623 LONG	VIEW LA.				OLNE		MONT	GOME	RY
Funeral Director		5. Sociel Security Number 278-12-3040	6. Sex 1 □ M 2/2 F		: last birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hr. Hours Min			9. Birthple Count OH I	ace (Stete or Foreign ny) IO
pue *	-	Usual Residence of Decedent 10e. Stete 10b. County	/	10c. C	ity, Town or Lo	cation				10	d. Inside City Limits
Maryli f aho	ŏ	MD. MONT	GOMERY			OLNEY					1X Yes 2 □ No
the 128s	Director	10e. Street and Number	. O COLLEGE			10f. Zip Code			10g. Citizen of V	n of Whet Country?	
72 hours after death with the Maryland natural', or items 23s or 25s-f show pical Essentrat or sat be notified as	by Funeral D	17623 LON 11. Maritel Stetus 1 Never Merried 2 Mar 3 W Widowed 4 Divorces	Armed	ecedent Ever in U Forces? as 2 1 No		Was Decedent of Information of Yes, specify Cub	lispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Rac	S.A. e - America ck, White, e	
<u>c</u>	Completed	15. Deceder (Specify only higher	nt's Education est grade complete	od)	(Give	dent's Usuel Occup kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Bu		
filed within Hygiene. ther than "	EO	Elementary/Secondery (0-12)	College	e (1-4or 5+)		HOMEMAKE	ER			HOME	
_ 0	Be C	17. Fether's Neme (First, Middle,	, Last)				18. Mother's Ne	me (First, Middle,	Maiden Sumem	10)	
Mental Marked Marked	10	LAWTON	TILLMA	n Jone	ES		FR	ANCIS AI	MA SI	EPHEN	IS
permit. Peges 1 and 2 sh Department of Health and Important: if item 27 ie m any Injury or other traum once.		STEPHEN ALLEN 20e. Method of Disposition Seriel 2 Cremetion Uponetion 5 Other (3)	PENDERGR 3 □ Removel from	20b.	MUHLI Plece of Dispo cemetery, crer	EN STRASS sition (Neme of netory or other ple	SE #3, GI	ELNHAUSEN Dete 2/21/00 L2/21/00	GERMA 20c. Location -	NY, A	APO AE wn. Stete Maryland
Physician /Medical Examiner		Immediate Ceuse (Final disease or condition	01	mande	100			1	1171842		
ficate be executed physician and is the burial-transit	edical Examiner	Sequentially fist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	e	Due to ((or as a consector es a consector es a consec	quence of):	C710£	rund	miny		many Yaan,
n certificate anding physuse as the	edical	Sequentially fist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	e	Due to ((or es e consec	quence of):	CTIVE				
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ending Physician: The law requires that the death certificate eath. or: After this certificate has been signed by the attending physithe funerel director, page 2 should be delached for use as the	To Be Completed by Physician/Medical	Sequentially fist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Part II. Other significant conditions are under the initiated events resulting in death) Last 25. Wes case referred to medical examiner? 1 Yes 2DNo 27. Manner of Death 1 Ziveturel 5 Pendi invest	d does contributing to for a contributing to for a contributing to	Due to (continue)	or es e consequence de la consequence del consequence de la consequence del consequence de la conseque	uence of): uenca of): uenca of): ndertying cause git out 3 □ DOA Otto f 28c. Inju Wo M 1 □	ven in Part I. 26. Place of Doese: 4□ Nursing	23b. Did 1 124a. Wes perfo 1 1 1 24a. Wes perfo 1 28d. Describe I	robsecto use convex 2 No en eutopsy med? res 2 No ene) dence 6 Oth now injury occur	24b. We eve con of c	the cause of death? webly 4 Unknown for autopsy findings fileble prior to fileble prior fil
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Hospital or Attending Physician: The law requires that the deeth certificate 24 hours after deeth. Funeral Director: After this certificate has been signed by the attending physelely filled in by the funeral director, page 2 should be detached for use as the	edical Certification: To Be Completed by Physician/Medical	Sequentially fist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Part II. Other significant conditions are under the initiated events resulting in death) Last 25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pendi invest 2 Accident 3 Suicide 6 Could determine the conditions of the could determine the could deter	d	Due to (Due to	or es e consequence de la consequence del consequence de la conseq	uence of): uenca of): uenca of): ndertying cause gif 28c. Inju Wo M 1 reet, factory, offica	26. Place of Doher: 4 □ Nursing ry et rk? I Yes 2 □ No me, date and place	23b. Did to the coursed at the time,	robacto use convex 2 No en eutopsy med? res 2 No ene) dence 6 Oth now injury occur Street end Numb vn, Stete) ceuse(s) and ma date and place,	anner as stand due to	the cause of death? webly 4 Unknown re autopsy findings illeble prior to ppletion of cause death? I Yes 2 No I Route Number, ated. the cause(s)
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State Registrar 31. Date filed (Month Dey, Year) DEC 1 9 2090

32. Pégistrar's Signature

Sports

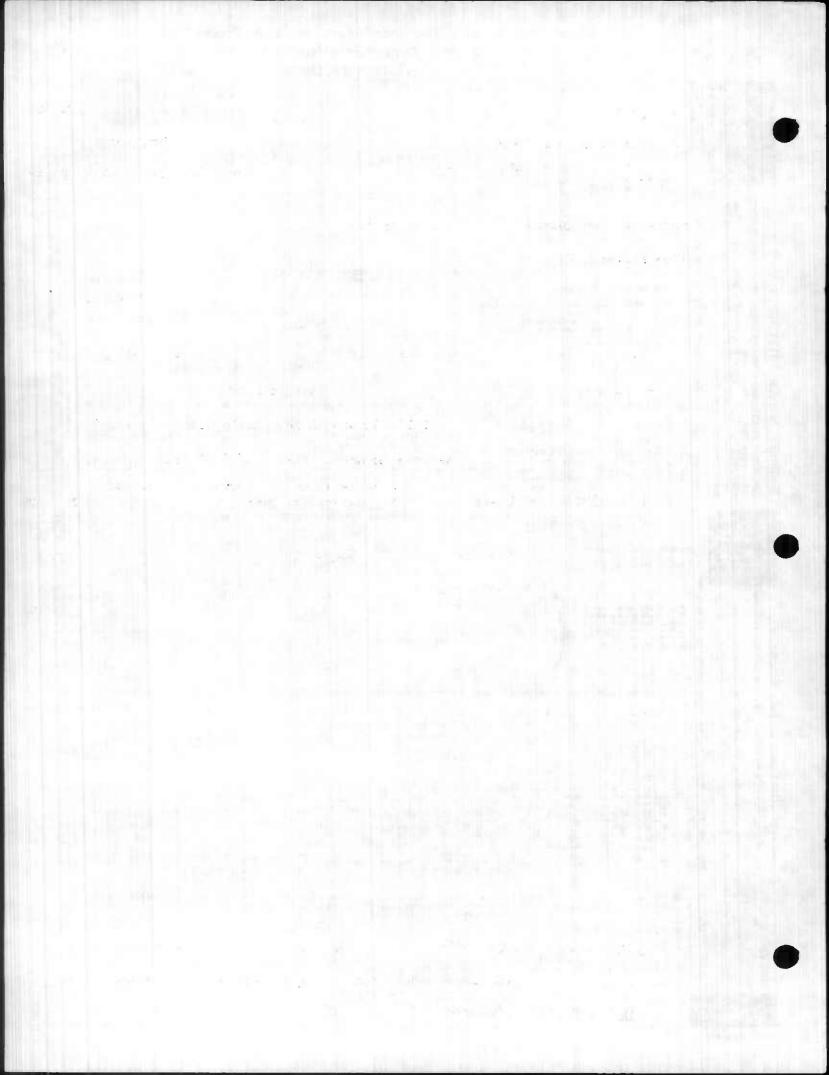
C. 13. TAMES (E. . 24) 34-0 • During Time . Co. . L. Cardell C ... a lakiba : CARL MARKET DAMES T northern again, committee, as subtile against the standard of The state of the s Eva Bradia - aca ALLES TO THE REPORT OF THE PARTY OF THE PART

Control of the forest see that the

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	1. Decedent's Name (First, Mid	idia, Last)						2. Data of De	Reg. No.	Yaar	3. Time of Death
Physician	Josephine P	appas							er 18,		4:00 am
/Medical Examiner	4a Facility Name (If not institut		umber)			- 1	b. City, Town, or	Location of Deat			reco am
LAdimine	Montgomery Ge	neral Hosp	ital				Olney		Mont	gomery	,
uneral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		r 1 Year	If Undar 24 Hrs	8. Data of Bir			nca (Stata or Fore
rector	578-42-6096 Usual Residence of Decadent	1□ M 2X) F	71	Yrs.	Months	Days	Hours Min	8. Data of Bir (Month, Da June 2	7, 1929	West	
28a-f show correct and are	10a. State 10b. Coun	ty	10c. C	ty, Town or Lo	ocation					10	d. Inside City Lim
8a-f		gomery	Si	lver S	-						
or 2	10e. Street and Number				10f. Zip	Code			10g. Citizen of	What Count	y?
23e	1103 Playford	Lane			209				USA		
al, or items 23s or 28s-1 sho Examiner must be not 1 ad at by Funeral Director	11. Marital Status 1 Never Married 2 Marital Midowed 4 ADivorce	Armed F arried 1 ☐ Yes	24 No live				lispanic Origin? (! an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Bla	ce - America ck, White, e Whit	tc.
d other than "natural", event, the Med cal Ex- Be Completed by	15. Deced	ent's Education nest grade completed)	16a. Dece	dent's Usu	al Occup	ation during most of wo	orking	16b. Kind of B	usiness/Indu	istry
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. To Be Completed	Elementery/Secondary (0-12		(1-4or 5+)		<i>po vot</i> u make i		1)		Own Hor	m.o.	
E O	17. Father's Nama (First, Middl	a. Last)		Home	maker	-	18. Mother's Na	me (First, Middle			
ed o		-,,									
To To	Henry Sprouse 19a. Informant's Name/Relation	nehin (Tuna Print)		10h Maili	ina Addrae	e (Stroot	Bessie	NITK Rural Routa Numb	or City or Town	State Zin I	Code)
7 is r trau			fill yes.								
ther the	Robin D. Cois 20a. Method of Disposition	/ Daugnter		Placa of Dispo			Road, C	larksvil	1e, MD 20c. Location		
2 6	1 Burial 2 □ Cremation		Stata	cemetery, cre	matory or	othar plac				1	
Jury	4 Donation 5 Other		Na					12/21/00	Falls	Church	ı, VA
any le	21. Signature of Funeral Service	w & Ca	le	5	ranci 00 Ur	ls J. niven	sity Bl	s Funera vd., W,	Silver	Spring	
/siclan	23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that ist only one dause on	caused the dea each line.	th. Do not en	ter the mod	de of dyir	ng, such as cardia	ac or respiratory a	rrest,		Approximate interval Between Onset and Death
edical miner	Immediate Cause (Final disease or condition resulting in death)	a. Pu	Due to (des	2 5	922	sis				2 Days
i i		ρ,	Due to (or as a conse	quenca of)	:					2 Days
rensit	Sequentially list conditions,	b		or as a consa							72
cian a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
attending physician and for use es the burial-trensit clan/Medical Examiner	that initiated events rasulting in daath) Last		Due to (or as a consac	quance of):						
ending r use		d									
sici	Part II. Other significant condi	tions contributing to d	death but not re-	sulting in the u	underlying	cause giv	en in Part I.	23b. Dld	tobacco use co	ontribute to	the cause of dea
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cate has been signed by the attending page 2 should be datached for use Completed by Physician/N	HTN							24a. Was	an autopsy ormed?	ava	re autopsy finding liable prior to apletion of cause eeth?
te has bega 2								10	Yes 2 No	10	Yes 2□ No
ls cartificate ha director, pega To Be Com	25. Was case referred to medic	cal					26. Place of De	eath (Check only	one)		
his car il direc	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 D	OA Oth	er: 4 Nursing	Home 5 ☐ Resi	dence 6 Ot	her (Specify)
5 8	27. Manner of Death 1 Netural 5 Pend 2 Accident invest	28a. Date (Moi stigation	of Injury nth, Day Year)	28b. Time o Injury	of M	28c. Injur Wor			how injury occu		
To the Funetal Director. After the completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 286. Plec	a of Injury - At h		reet, factor	y, office		28f. Location (City or To	Street and Num wn, State)	ber or Rural	Route Number,
e Funera pletaly fille		ring Physician: To the al Examiner: On the b and man									
N Som	29b. Signature and title of certif	. (1			29	c. Licens	a number		29d. Date signa		
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DHMH 16 Rev 6/95



00-7183- 031 JUSTO Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical Examiner

Funeral Director

. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heelth and Mentel Hyglene. It is marked other then "naturet", or items 23s or 28s-4 show jury or other treumstic event, the Medical Eventment must be notified at

Physician /Medical Examiner

permit. Page Department of Important: If eny Injury or

Baltimore,

attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Records, P.O. Box 68760 been signed by the should be detached has be 2 page certificate Division of Vital Physician: this After To the Hospital or Attending death Director: / efter within 24 hours or To the Funeral I

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year DECEMBER 13,2000 6:30A.M. JUSTO PALENCIA 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death MONTGOMERY SUBURBAN HOSPITAL BETHESDA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In vrs. last birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) Deys Months Hours Min. 67 June 6, 1933 126-44-5491 Guatama1a Usuel Residenca of Decedent 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 20906 3506 Weller Road Guatamala Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No ff Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Status Bleck, White, etc. 1 Never Merried 2 Married Specify: Guatamalian 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baker Grocery Store 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Eduardo Palencia Felicita Reyes 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Dino L. Palencia / Son 3506 Weller Road, Silver Spring, MD 20906 20e. Method of Disposition
14 Buriel 2 □ Cremetion 3 💆 Removel from State 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) Hosanna Cemetery 12/20/00 Guatemala, Ciudad 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 1 Pent | Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart feilure. List only one cause on each line. MD 20901 Approximete Interval Between Onset end Death Immediate Cause (Final diseese or condition resulting in death) Due to (or as a consequenca of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in lease to the cause of the cause Due to (or es e consequence of) Physician/Medical that initieted events resulting in death) Last Due to (or es e consequença of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. No 1 Yes 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No Yes 2 No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1⊠ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury 27. Manner of Deeth 28b. Time of 28. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation Injury edestran Ing 1 Naturel 0545 113/00 1 Tyes byve 2 Suicident 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number City or Town, Stete) 6 Could not be 4 ☐ Homicide orned with the SARETT 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier 29b. Signatu 29c. License number 29d. Dete signed (Month, Dey, Year) O.C.M.E. DECEMBER 14,2000 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 10

State Registrar 31. Date filed (Month, Dey, Year)

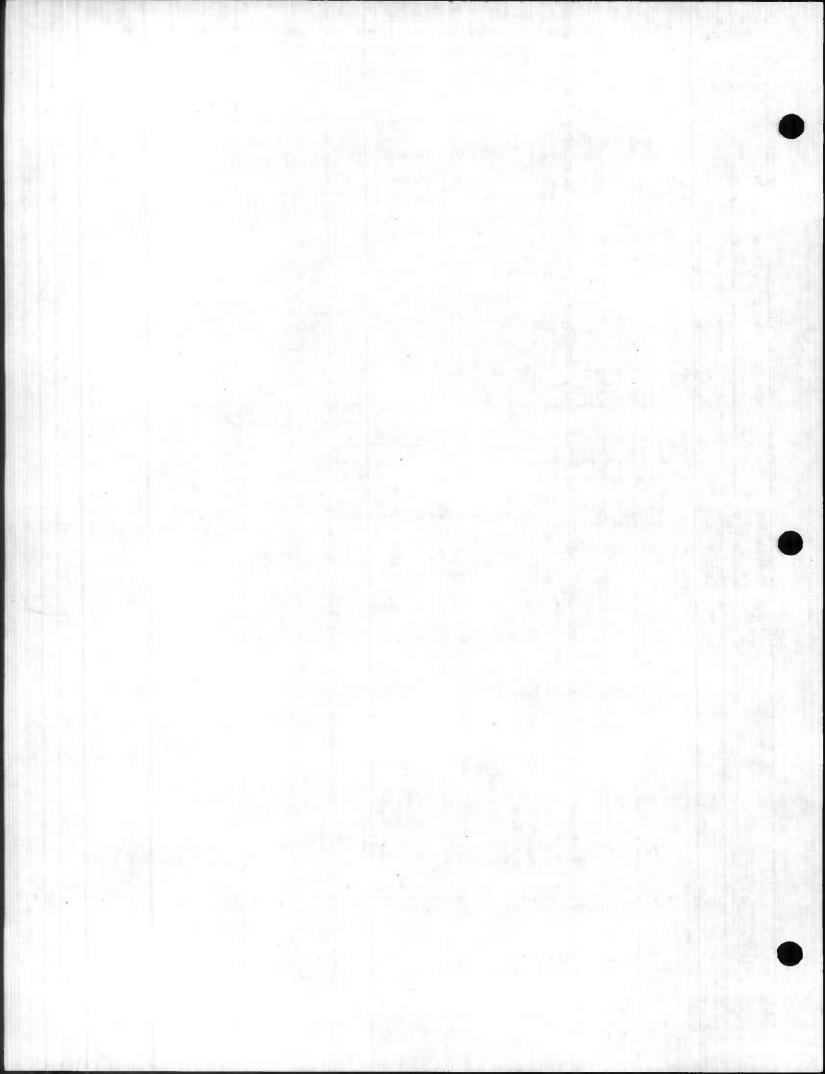
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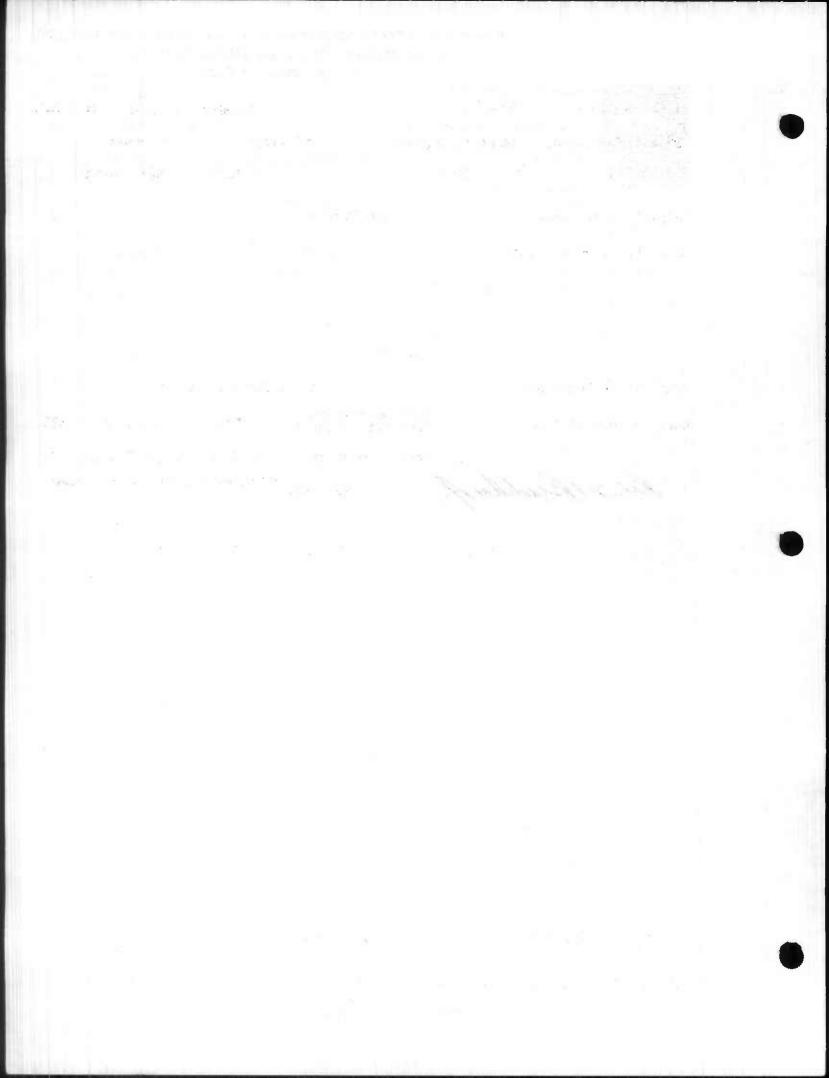
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32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 00 42209

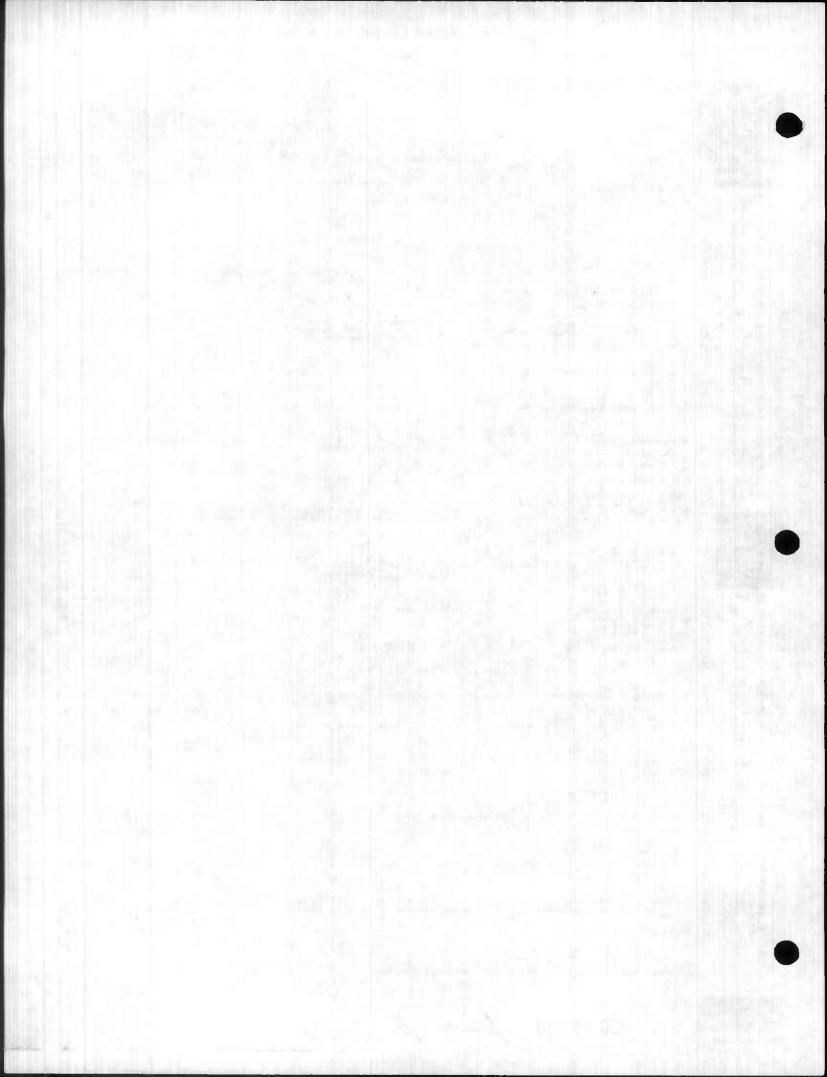
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ieled within 72 hours attar death with the Maryland tal Hygiene. d other than "natural", or items 23s or 28s-f show event, i're Modical Examiner mant be notified at	al Director	10e. Street and Number 28673 L. Q. Powe.	11 Road			10f. Zip		1838			10g. Citizan of U	What Cou	ntry?
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al', or its	þ	1 Nevar Merried 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Giva Year or Dates:			Yes 2		Specify:	i, ruaito	nicari, atc.)	Speci	eck, White, ify: Wh	ite
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nant of Ha		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		20b. Placa o	of Dispos	sition (Nem	e of ther ple	ce)	1:	Date 2/19/00	20c. Location		own, Stete ation, M
Department of Haalth important: if Item 27 any Injury or other tr		21. Signatura Funeral Service Lice	0	ud.	22.	Nama and	Addra Ma:	ss of Facilit	y Br	adshaw 8	& Sons	Fune	ral Home
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/Medicai Examiner	ner	immediata Cause (Final disease or condition resulting in daath)	. Dissi	Due to (or as a			01	/ARI	AN	CAr	VCEI		
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aftar dar Director d in by th	Certification:	3 Suicide 6 Could not b 4 Homicida determined	28e. Place of in	jury - At home, fac. (Spacify)	arm, stre	et, factory,	, office			28f. Location (S City or Tow		ber or Run	ral Route Number,
	edical C	29a. Certifier 1 Cartifying Ph (Check only one) 2 Medical Exam	ysicien: To the best niner: On the basis of and manner si	of examinetion ar	e, death nd/or inve	occurred a estigation,	it tha tir In my o	na, data an pinion, dea	d piece, th occurr	and dua to tha ded at tha time, d	euse(s) and n data end place	nannar es s	stated. to the ceuse(s)
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	-	30 Name end address of person who	completed cause of	death (Itam 23a)	(Type, F	Print)	°H7	,	11	EMAIN	STR	EE7	21817.
Char	0	31. Data filad (Month, Day, Year)	32. Regist	far's Signature	,		1			-1~(3 F ()	١ / رك	1 1	
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Funeral	5. Social Security Number 6. Sa			Under 1 Yeer onths Days	If Undar 24 Hrs. Hours Min.	8. Data of Birt (Month, Da	h v. Yaer)	9. Birthpi	ace (Stata or Foraign ry)
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ORIGINAL



Funeral Director

death with the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at filed within 72 hours after Hygiene. permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If Item 27 Is marked other?

aitimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the deeth certificate be executed physicien end is the burial-trans Division of Vital Records, P.O. Box 68760, for use es the signed by the should should page 2 his certificate h ai or Attending Physician: The safter death.

I Director: After this certificated in by the funeral director, pa To the Hospital or within 24 hours aft To the Funeral Di completely filled in

1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death December 17, 2000 2:55 am Pablo Salamanca Quintamilla 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Montgomery Rockville 6301 Montrose Rd If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec. 20, 1944 9. Birthplaca (Stata or Foraign El Salvador 5. Social Sacurity Number 6. Sex 1 → M 2 □ F 7. Aga (In yrs. last birthday) Months Days Min. Hours 55 Yrs 212-33-4115 Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Rockville Maryland Montgomery Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20852 United States 6301 Montrose Rd Funeral 12. Was Decedant Evar in U,S.
Armad Forces?
1 ☐ Yas 2 No
If Yas, Giva
Yaar or Datas: Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married 1∰Yas 2□No Specify: Salvadorian Specify: Hispanic þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Synagogue Building Supervisor 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Eva Salamanca Monico Quintamilla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 6301 Montrose Rd. Rockville, MD 20852 Bertha Salamanca/ wife 20a. Mathod of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata cematary, cramatory or other place) 1 Burial 2 Cramation 3 Ramoval from State San Miguel, El Salvador San Miguel Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Rapp Funeral & Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Between Onset and Death Immediata Causa (Final a. Cancer Hepatoma 1 month disaesa or condition resulting in deeth) Dua to (or as a consaquance ot): Examiner 2 years End-Stage Liver Disease Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequance of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes p 24b. Were eutopsy findings available prior to complation of causa of daath? Completed 24a. Was an autopsy 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical Be 26. Piece of Death (Check only ona) axaminar? 1 Yas 2 No Other: 4 Nursing Homa \$ Rasidence 6 Othar (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Time of 5 Pending invastigation 1 Neture!

29a. Cartifian

2 Accidant 3 Suicida

4 Homicida

To the best of my knowledge, daeth occurred et the time, date end plece, and due to tha causa(s) end manner es stated.

| Description of the best of my knowledge, daeth occurred et the time, date end plece, and due to the causa(s) end manner es stated.
| Description of the best of my knowledge, daeth occurred et the time, date and place, and due to the causa(s) end manner es stated. and mannar stated. 29b. Signatura and titla of certities AIAND (. of hmidt

29c. Licensa number D00 54

1 ☐ Yas 2 ☐ No

300

29d. Data signed (Month, Day, Year) 12/19/00

281. Location (Street and Number or Rural Route Number, City or Town, Stata)

DAIANA Jehmid 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

6111 Executive Blvd. Rockville, MD 20852

State Registrar

Medical

31. Data tiled (Month, Day, Year) DEC 1 9 2000

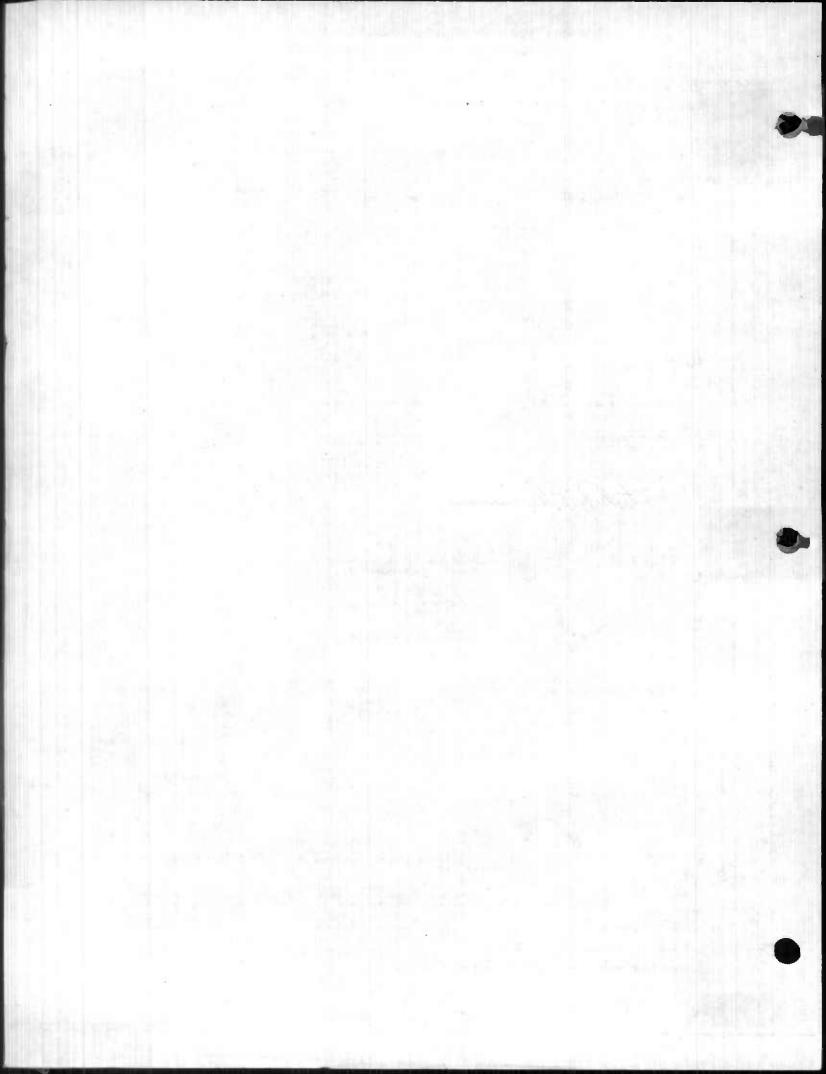
Daiana Schmidt M.D.

6 Could not be detarmined



28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene REPLACEMEN Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dala of Death 3. Time of Death Month **Physician** 15 2000 Kiet N. Quach December 2:20 pm /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** 12 M 2□ F Months Days Hours Min. Yrs. Director 72 Feb. 29 1928 Vietnam 177-60-7833 Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yas 2 No Directo MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iner must be n 7108 Cypress Hill Drive 20879 United States Funeral 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14 Race - American Indian the Medical Examiner Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Never Married 21X Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yas 2 No Specify: Specify: Asian à 3 □ Wildowad 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Electrical Engineer 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) permit. Pages 1 and 2 should be fin Department of Health and Memial H Important: If Item 27 is merked oth any Injury or other treumetic even 88 Ken Man Ke Mau 2 Thi Si Tchang Im Yong 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Numbar, City or Town, Stata, Zip Coda) Hoa Q. Thach / Spouse 7108 Cypress Hill Drive, Gaithersburg, MD 20879 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Dec. 19 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Rockville, MD 2000 Parklawn Memorial Park 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility DeVol Funeral Home, 10 Deer Park Drive, Gaithersburg, MD 20877 10 East Gary M. Gise per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical SEPTIC SHOCK 5 DAYS Examiner Dua to (or as a consequence of) Examine 3 MONTHS RECTAL CARCINOMA the death certificate be asscuted og physician and as the burial-trans Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaase or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Box 68760 TRANSITIONAL CELL BLADDER CARCINOMA 21 DAYS Physician/Medicai Due to (or as a consequence of): attanding 3 MONTHS LIVER AND BONE METASTASIS USB signed by the a P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE Division of Vital Records. P 24b. Wara autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy HYPOTENSION certificate has lirector, pege 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No HEMATURIA To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica complataly filled in by the funeral director. 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding Invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a, Certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura, and titla of certifier CENT D41162 December 15, 2000 1401 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Ganti, M.D., 19529 Doctor's Drive, Germantown, Maryland 20874 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Rev 6/95

State

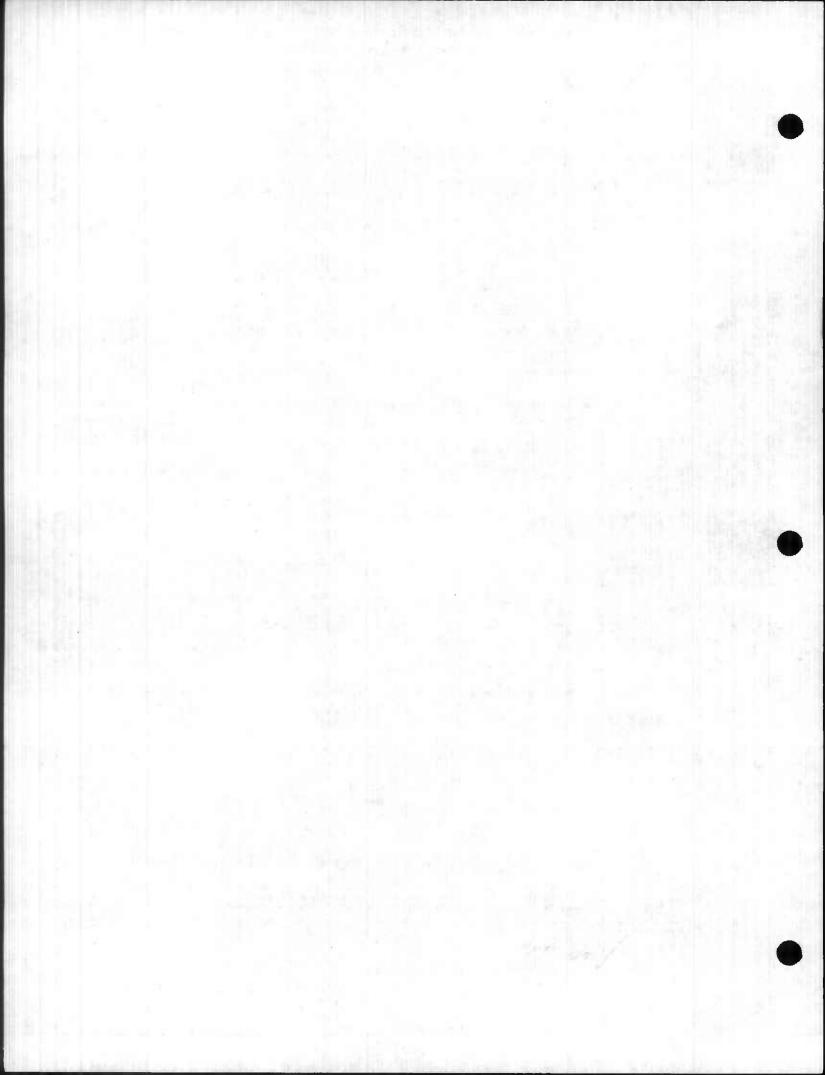
Registrar

28

FEB

ORIGINAL

General



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month DECEMBER 14, 2000 1:30PM ELAINE WYNER ROSS 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY ROCKVILLE HEBREW HOME OF GREATER WASHINGTON 8. Data of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign Country) 1925 NEW YORK Days Months Min. 1 M 2 CKF Hours APRIL 15, 078-18-2184 Usual Rasidance of Dacedan 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits PALM BEACH BOCA RATON 1 Yas 2 No FLORIDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33434 USA 302 BRIDGEWOOD COURT 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ≥ ☐ YNo If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc 1 Navar Married 2 Married WHITE 1 Yes 2 XNo Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) U.S. NAVY-Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER CIVILIAN OFFICES 12 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) MINERVA ZUCKER MEYER BOLOKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 17392 CORCORAN STREET, NW, WASHINGTON, D.C. 20009 DR. STEVEN WYNER/SON 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata DEC 15, 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 2000 FARMINGDALE, NEW YORK BETH MOSES CEMETERY 22. Nama and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death 10days Immediata Causa (Final diseasa or condition rasulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, laading to immadiata causa. Entar Undartying Causa (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy 1 ☐ Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

man be notified at

Нота 23а

be filed within 72 hours efter dintal Hygiene.
diother than "natural", or fremewent, the Medical Example. "natural", or item

Dearmit Peges 1 and 2 should be file Department of Heelth and Mental Hy, Important: If item 27 is marked other my injury or other traumatic event, 1

Director

Funeral

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Completed

Be

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death

Baltimore, Maryland 21215-0020

attending physician and for use es the burial-trensit signed by the a The law requires thet page I or Attending Physician: after deeth. Director: After this certifica funerel director.

Physician/Medical Examine by Be Completed Certification: To

Box 68760, P.O. Records. of Vital

> within 24 hours at To the Funeral D completely filled To the Hospital

Division

illed in by

edicai

Registrar

State

30, Nama and addrass

295. Signatural and title of certifian

27. Manner of Death

1 Natural

2 Accidant 3 Suicide

4 Homicida

29a. Certifier

MOTO

5 Panding investigation

6 Could not be datamined

28a. Data of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 Yes

2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

28d. Describe how injury occurred

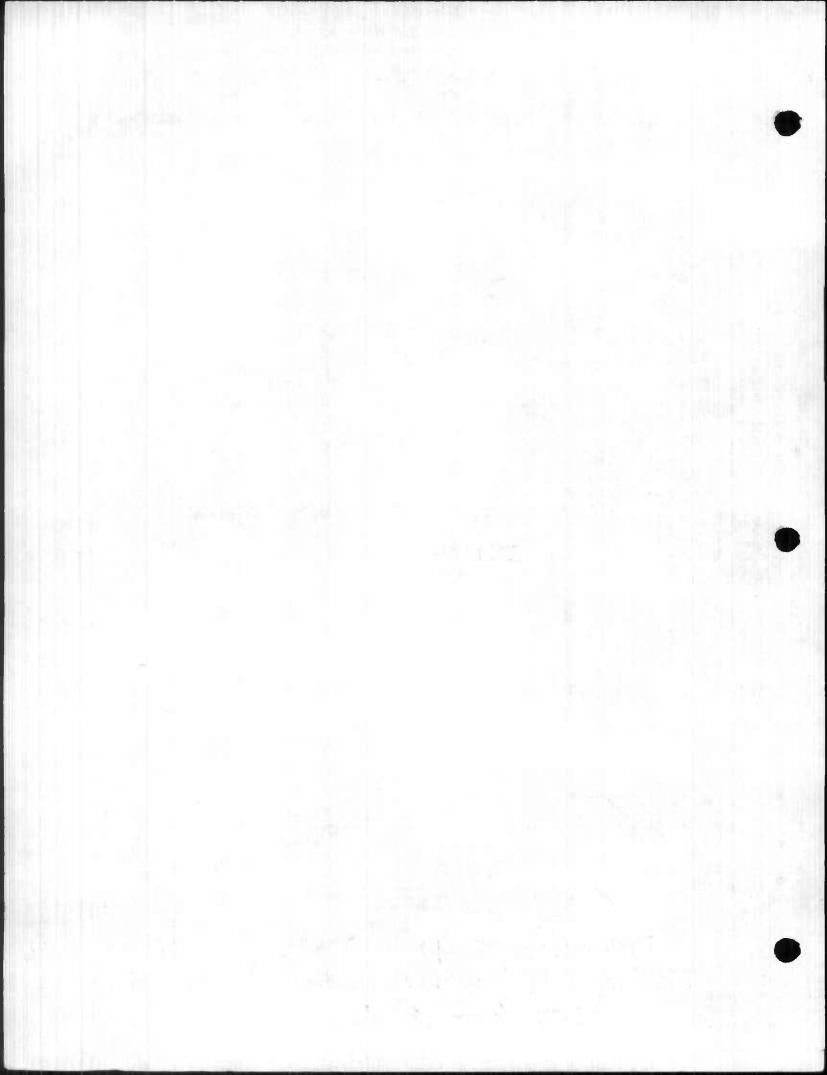
se of death (fiem 23a) (Type, Print)

MD 31. Data filed (Month, Day, Year) DEC

18

6121 Montrose Rd. Rockville, MD 20852 Begistrar's Signature

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)



Physician	1. Decedent's Nama (First, Midd	eth Po	rore De		ertificate	e UI	Dealli		2. Dete of E	Reg. No	¥7,	2 ^Y 000	3. Time of Death 2:49 AM
/Medical	4a Facility Nama (If not institution			cne			4b City To	wn orl	Decen			y of Death	2:49 AM
Examiner	3143 Brooklawn		77.				Chevy					gome	ry
Funeral Director	5. Social Security Number 139–32–8701	6. Sex 1 ☐ M 2		n yrs. last birthde	y) If Under Months	1 Yaar Deys		24 Hrs. Min.	8. Data of E (Month, I June 2	Birth Day, Year	40	9. Birthp Cour New	olaca (Stata or Foraign htry) Jersey
	Usual Rasidence of Decedant 10a. Stata 10b. County		1	0c. City, Town or	Location							1.	Od Incide City Limite
or 28a-f show be notified at Director	Maryland Mont	gomery			Chase								0d. Insida City Limits 1 ☐ Yas 2 No
Dire	10e. Street and Number 3143 Brooklawn	Terrac	0		10f, Zip	Code 208	315				itizen of What Country?		
al' or tems 23e or 25e-f al Examiner must be notified by Funeral Director	11. Marital Status 1 Naver Married 2 Mar 3 Widowed 4 Divorced	12. Was Arm	s Decedant Evened Forcas? Yas 2 🖾 Noes, Giva	ar in U,S.	3. Was Deced If Yas, spec	dent of I	Hispanic Or ben, Maxicai	gin? (Sp n, Puerto	pecify Yas or Po Rican, etc.)		14. Rac	ce - Amaric ick, Whita,	en Indian, atc.
or than 'natural, it the Medical	15. Deceder (Specify only highs Elementary/Secondary (0-12)	Coll	lege (1-4or 5+)	(Gi life	cedent's Usua va kind of wor DO NOT us	rk dona sa retire	i during mos ed)	t of work	king	16b. Kind of Businass/Industry U.S. Government			
Be Be	17. Fathar's Nama (First, Middla, Walter Power	Last)	+	Pro	gram A	nar)	18. Moth		na (First, Midd ced Woo	lla, Maide			iiCIIC
27 is marke r traumatic To	19a. Informant's Name/Reletions Thomas B. Roch	ship (Type, Pnin							ral Routa Num e, Chev				code) yland 2081
ant or man ht; if item ry or othe	20e. Mathod of Disposition 1 🖾 Burial 2 Cremation 4 Donation 5 Other (5	3 □Ramovel		20b. Place of Discamatary, of St. Mar	ramatory or o	thar pla		D	ec. 21,			- City or To	wm, State W Jersey
Depar Impor	21. Signature of Funeral Service 23a. Pert1. Entar tha disaasa, o shock, or heart failura. Lis	~		100198	7557 W Bethes	isco da,	onsiñ Maryl	Aver	nue 2081	4-350	me/I	Bethe: Ch	sda-Chevy ase, Inc. Approximata Intervel Batween Onset end Death
Medical xaminer	Immedieta Causa (Final disaasa or condition resulting in death)	a	Ha	a to (or as a cons	Fair	ler	R.	3/0					z weeks
attending physician and dor use as the bural-transit claryMedical Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Diseesa or injury that initiated avents rasulting in death) Last	b c d	colo	a to (or as a cons	ren	sta	ين حل						year.
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ifficate lor, pag	OF Mos sace referred to medical							15			2 /S.No	16	Yas 2 No
	25. Was cesa refarred to medica axaminar? 1 Yas 2 No	Hospital	1 Inpatient	2 ER/Outpa	ient 3 DC	OA OI	ther:	of Dee	th (Check onlowed)		6 □OH	har (Specil	(v)
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after death. Diractor: After thi I in by the funeral ertification: 1	1 Natural 5 Pandii 2 Accident Invest 3 Suicide 6 Could	not be	Place of injury building, atc.	- At homa, farm, Specity)	street, factory	y, office				Town, Sta		ber or Hun	al Route Number,
2 -	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Cartifiar 5 Pandii Invest 6 Could detam	not be all the second s	building, atc. (Specify) ny knowledge, de aminetion and/or	eth occurred	at tha t	tima, deta ar	d place,	City or 1	Town, Sta	te) s) end m	nenner as s	stated.

State Registrar

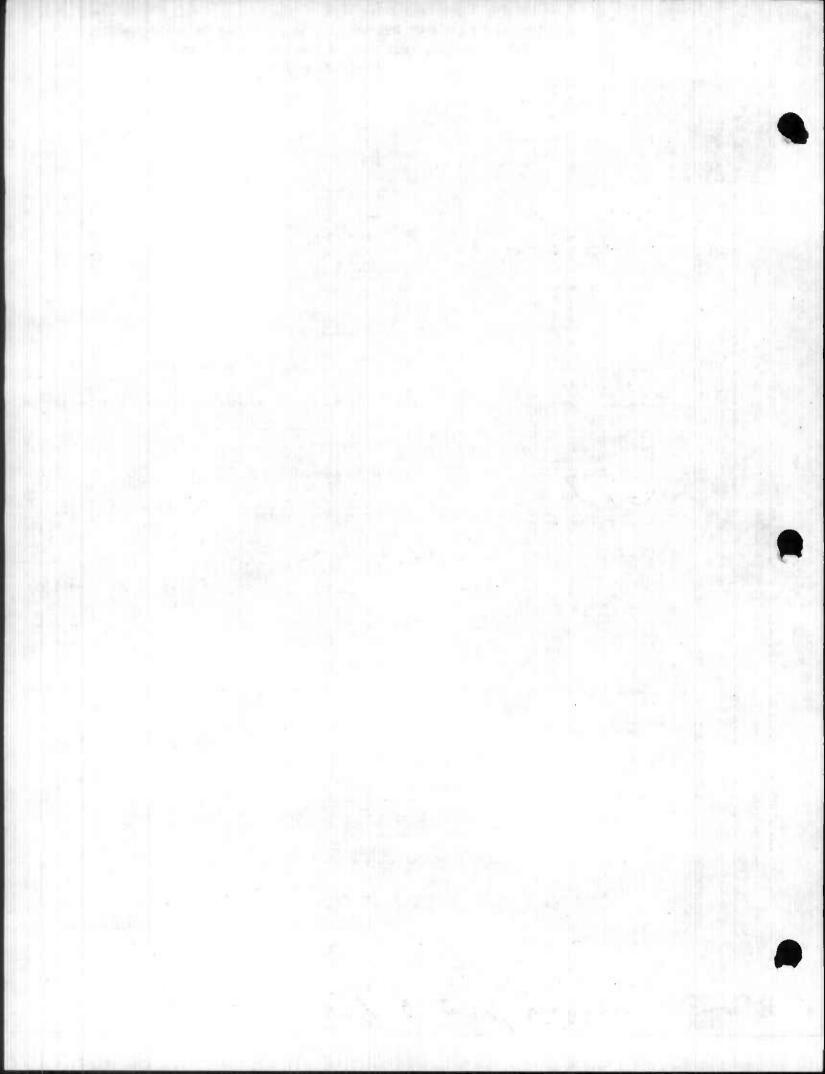
DEC 1 9 2000

James D. Ahlgren, M.D. 2150 Pennsylvania Avenue, N.W. Washington, D.C.

31. Data filed (Month, Day, Year)

32. Begistrer's Signatura 32. Registrer's Signatura

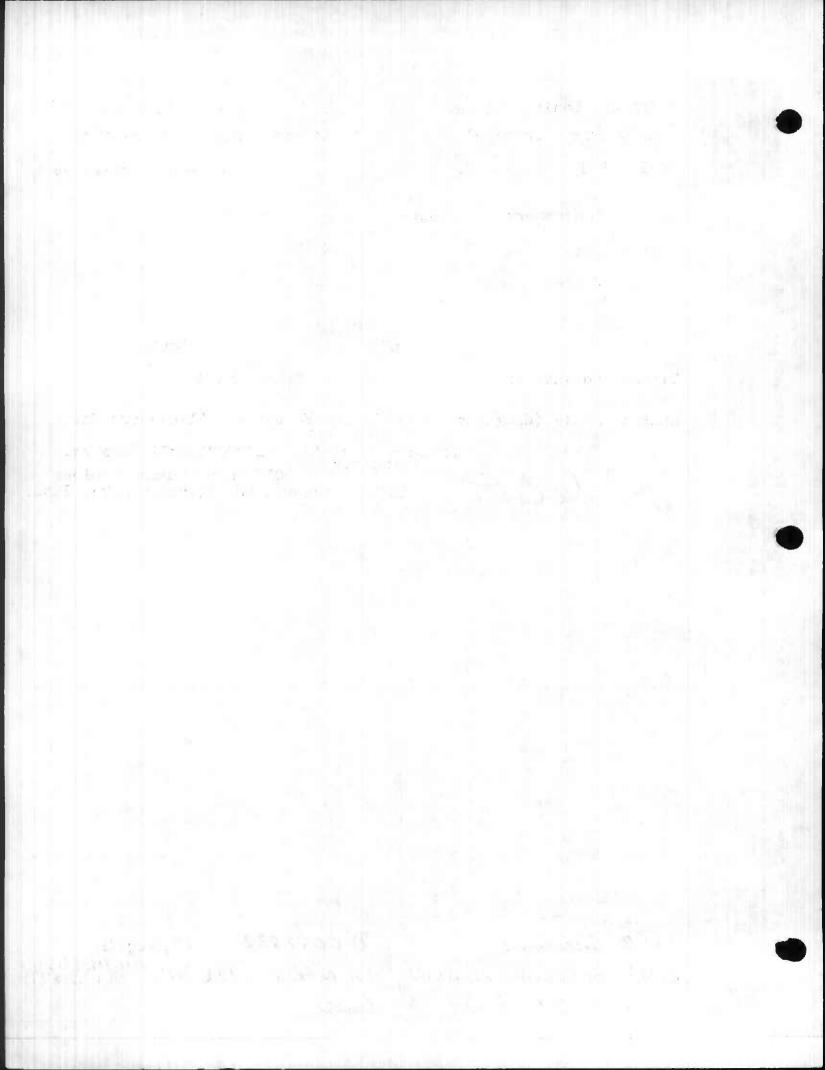
20037



State of Maryland / Department of Health and Mental Hygiene 1 4 2 2 1 5

Certificate of Death

Residence of Decedent tate 10b. County Mont Treet and Number D 11 Randolp rital Status Never Married 2 Married Widowed 4 Divorced Specify only highest Interest and Number O 11 Randolp O 11 Randolp O 12 O 15 Decedent's (Specify only highest O 16 O 17 O 18 O 19	give street end number) Hospita S. Hospita S. Hospita S. Hospita T. Age 1 M 2 F 7. Age 1 M 2 F 7. Age 1 M 2 M 5	1 10 (In yrs. lest bir 77 10c. City, Town Whea Ever in U,S. 0 N/a 16a.	Yrs. Months m or Location ton 10f. Zi 13. Was Decellif Yes, specific Yes.	Silve der 1 Year If Under s Days Hours Zip Code 20902 Dedent of Hispanic Ori Decity Cuban, Mexicar 2 No Specify: Sual Occupation work done during mosuse retired)	igin? (Specify Yes or N n, Puerto Rican, etc.) st of working	Day 17th 4c. County MO1 Sirth Dey, Year) 5/1923 10g. Citizen of USA No- 14. Rac Blat Specify 16b. Kind of Bi	9. Birthplace (State or F Country) Pennsylvar	
Holy Cross at Security Number 8-19-0695 Residence of Decedent rate 10b. County Mont reset and Number 11 Randolp rital Status Never Married 2 Marrie Widowed 4 Divorced 15. Decedent's (Specify only highest) rests Name (First, Middle, Late) 1 Ctor Coug formant's Name/Relationship adrea Kels athod of Disposition Burial 2 December 13	give street and number) Hospita S. Hospita S. Sex 1 M 2 F R. Gomery The Road 12. Was Dacedent E. Armed Forces? 1 DXYes 2 M If Yes, Give Year or Dates: S. Education grede completed) College (1-4or 5- ast) The nour	1 10 (In yrs. lest bir 77 10c. City, Town Whea Ever in U,S. 0 N/a 16a.	Yrs. Months The or Location The or Loc	Silve der 1 Year If Under s Days Hours Zip Code 20902 Dedent of Hispanic Ori Decity Cuban, Mexicar 2 No Specify: Sual Occupation work done during mosuse retired)	Dec. own, or Location of Dec. er Spring 24 Hrs. Min. 8. Date of E. Month, I. 0 3/25	17th 4c. County Mo1 Sirith Dey, Year) 5/1923 10g. Citizen of V USA No- 14. Rac Blac Specify 16b. Kind of Bi	y of Death ntgomery 9. Birthplace (State or F. Country) Pennsylvan 10d. Inside City L 1 2 Yes 2 I What Country? ce - American Indien, tck, White, etc.	
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11/1	I A A	7					al Choices	
IR D	elosla	/					ria, Va. 22:	
1. Enter the disease, or concern, or heart failure. List or	nly one cause on each line	9.	TOT GITTED THE THE	ndo or dying, such as	cardiac or respiratory	arrest,	Approximate Interval Betwee Onset and Dea	
iate Cause (Final	METAS:	TATTC	BREAS	T CANCE	g r			
e or condition g in death)	a				217			
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ntially list conditions, leading to immediate Enter Underlying (Disease or injury	Mr	Due to (or as a consequence of):						
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Other standiles at a said to					1 2 2			
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of c			
					1	Yes 2□ No	3 □ Probably 4 □ Uni	
					242 Wa	s an autopsy	24b. Were eutopsy findi	
					performed? available prior to completion of cal			
							of death?	
					1	Yes 2No	1 ☐ Yes 2 ☐ No	
	Hannball			_	of Death (Check only	one)		
s case referred to medical miner?	1 Inpatien	t 2□ER/Out	patient 3 De	OA Other: 4 Nu	rsing Home 5 - Res	sidence 8 □Oth	ier (Specify)	
miner? Yes 2□∭No	28a. Date of Injury (Month, Dey	28a. Date of Injury (Month, Dey Yeer) 28b. Time of Injury Work?				28d. Describe how injury occurred		
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miner? Yes 2 No ner of Death Natural 5 Pending Accident investigat					28f. Location City or To	28f. Location (Street end Number or Rural Route Number, City or Town, State)		
miner? Yes 2 □ No Iner of Death Natural 5 □ Pending Accident investigat Sulcide 6 □ Could not	t be 28e. Place of Injur	,			3.1, 0. 10	, 5.4.0/		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Alice R. Richards 2030 December 18, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Clinton Southern Maryland Hospital Prince Georges 8. Data of Birth (Month, Dey, Year) If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (Stata or Foreign Country) **Funeral** Days 1 M 2 XF 95 Months Hours Min. Oct. 1, Alabama Director 579-58-5149 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No N/A N/A Directo Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours after death with that Mehalth Hydison.
7 is metried other than "netural; or literine 23s or traumatic event, the Medical Examiner, must be 1306 Franklin Street, N.E. Funeral United States 12. Was Decedent Ever in U,S. Armad Forcas? 1 ☐ Yas 2 ②No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien Black, White, etc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black by 3 ¥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 3 Education Teacher 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surneme) Be Perry Rousseau Hattie Snow 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Pages 1 and 2 a ment of Health an Department of Health Important: If Nem 27 1306 Franklin Street, N.E. Wash., D.C. 20017 Sandra R. Lucy 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/27/00 Arlington, VA Arlington National 21. Signature of Funeral Service Lice 22. Name end Address of Fecility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 20012 Pert1. Enter the disease, or complications that causad tha daath. Do not antar tha moda of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximata Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition rasulting in daath) /Medical Examiner Examiner attending physician and for use as the burial-transit that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Lest Physician/Medical Due to (or es e consequence of) 88 Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the causs of death? à 1 Yss 2 No 3 Probably 4 Unknown by 24b. Ware eutopsy findings availabla prior to completion of ceuse of death? After this certificate has been a funeral director, page 2 should Completed 24a. Wes an autopsy Michaels, Alice 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medicel 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Othar: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yes 2 No Lo 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral Certification: Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 Yas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and place, and due to tha cause(s) and mannar as stated.
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the tima, date end place, end due to the cause(s) and mannar stated. 29a. Certifier edica (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c, Licanse number 12.19.00 30. Nama and address of person who completed ceysa of daath (Itam 23a) (Type, Print)

Registrar

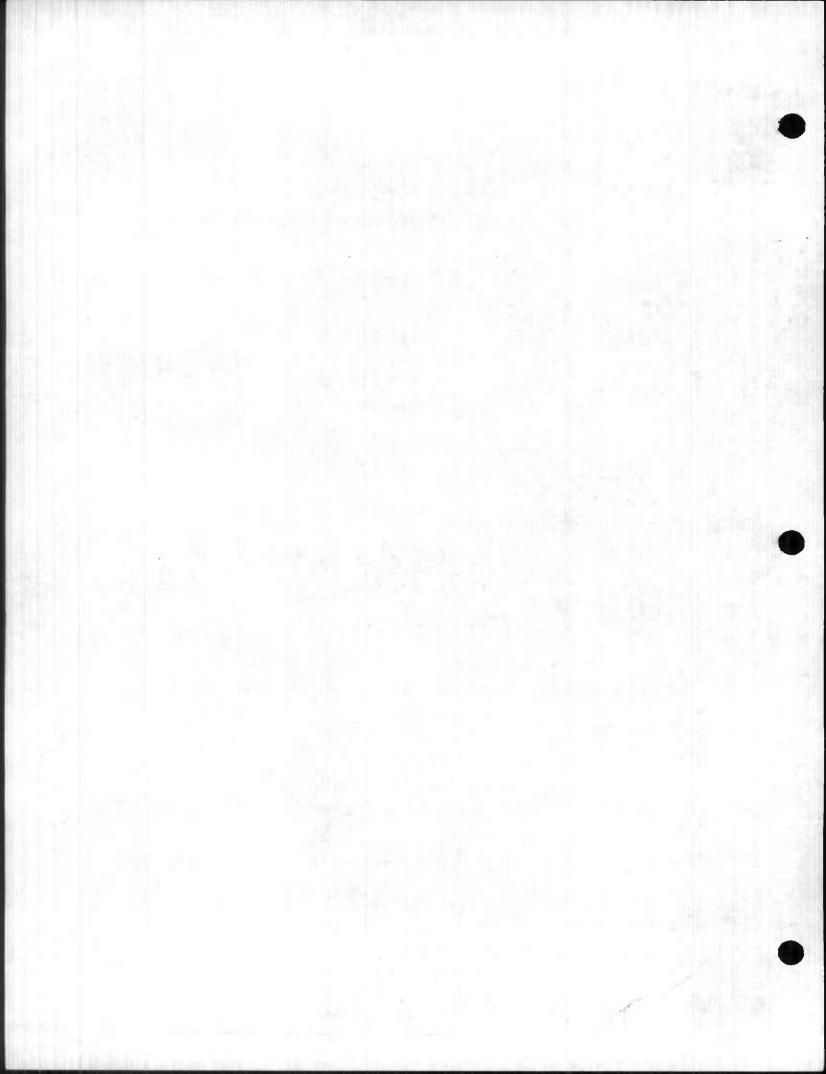
31. Dete filed (Month, Day, Year) Penerson DEC 21 2000

Laxmi N. Berwa, M.D.

32. Registrer's Signeture

porks

7700 Old Branch Avenue, Clinton, MD 20735



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Year **Physician** 19, 2000 12:20 am Charles Walter December Rich, Sr. /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Yeer | If Undar 24 Hrs. 5. Social Sacurity Number 6. Sex. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpiece (State or Foraign Country) Funeral Davs Hours Months Yrs 91 Sept 10, 1909 Director 718-10-6180 Usual Rasidence of Decedant 10a. Stata 10c. City, Town or Location 10b. County 10d. fnslde City Limits than "natural", or items 23s or 25s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Frederick Mt. Airy Pa 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 21771 USA 13946 Prospect Road Funeral 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Wes Decedent Ever in U,S Armed Forcas? 14. Race · Amarican Indien, 11 Marital Status Black, Whita, atc. 72 hours after 1 XYas 2 No ff Yas, Giva 1 Nevar Married 2 Married 1 Yas 2 No Specify Specify: White à 3 Widowed 4 □ Divorced Yaar or Datas: WWTT Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry filled within 1 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Southern Railways 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be find Department of Health and Mental. Highertant: If Item 27 is marked other years were Be Mary Fulton Charles W. Rich 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 13946 Prospect Road, Mt. Airy, MD 21771 Barbara Abell / Daughter Baltimore, 20a. Mathod of Disposition 20b. Plece of Disposition (Name of camatery, cramatory or other place) Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 12/22/00 Brentwood, MD Fort Lincoln Cemetery 22. Name and Addrass of Facility.
Francis J. Collins Funeral Home, Inc. 21. Signature of Juneral Service Lic 500 University Blvd., W, Silver Spring, MD 20901 23a. Perti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician /Medical Immediata Causa (Final Days Aspiration Pneumonia diseasa or condition resulting in daath) Examiner Dua to (or as a consequence of): Examiner Cerebrovascular Disease Months sician and burial-transit certificate be asscuted Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Diseasa or injury that initiated evants rasulting In death) Last Dua to (or as a consequence of): physician a Physician/Medical Dua to (or as a consequence of): 88 attending p signed by the a 23b. Dfd tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 1 Yes 2 No 3 Probably 4 Unknown that by 24b. Wara autopsy findings evailable prior to complation of cause of death? should l 24a. Was an autopsy Completed law. page 2 certificate has PH-1 Yas 2 No 1 ☐ Yas 2 No Physician: director, 25. Was casa rafarred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4₺ Nursing Homa 5□ Rasidanca 6□Othar (Specify) 1 Yas 2 No 2 this daf or Atta.

Jurs after death.

Ineral Director: After the funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Manner of Death Certification: 28b. Tima of 28c. Injury et Work? Natural 5 Panding 1 Yas 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 - Homicide 🛣 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. Medical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760. o Records, Division of Vital To the Hospital within 24 hours a To the Funeral I completely filled

(Check only one) 29b. Signatura and titla of certifier

29c. Licansa number

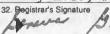
D 051610

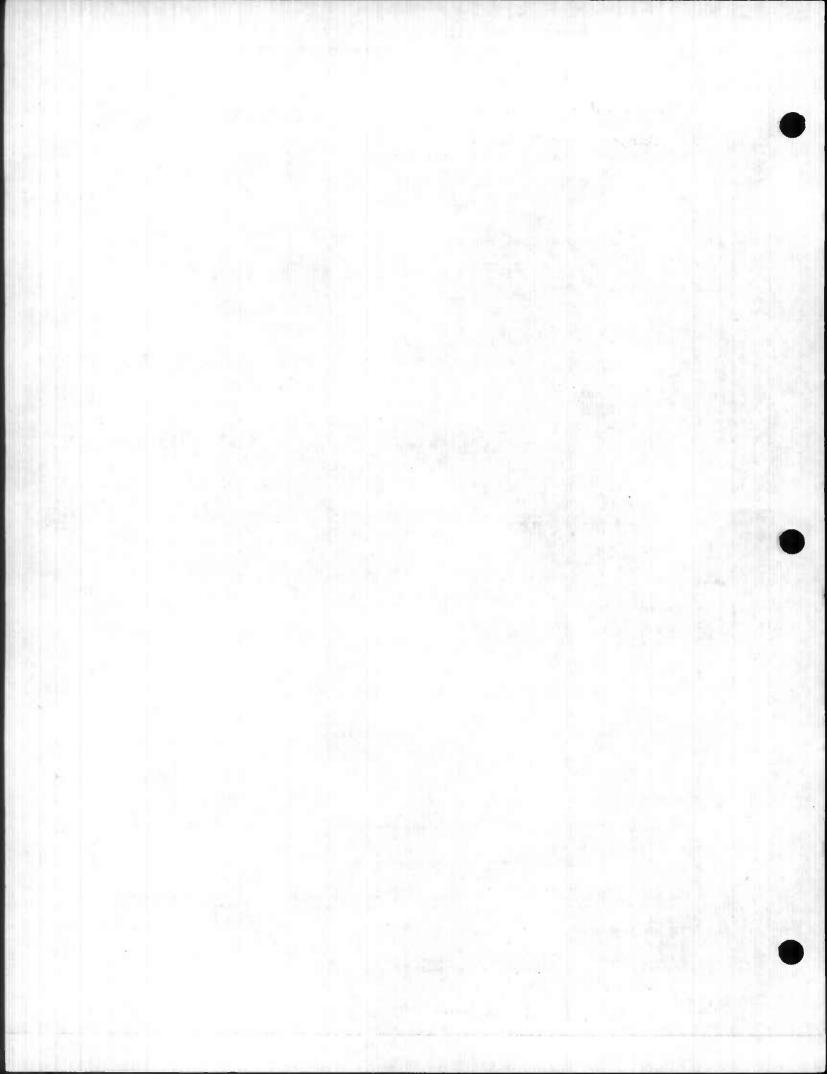
29d. Date signed (Month, Day, Year) December 19, 2000

MO 6 30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print)

1475 Taney Ave., Mike Tolino, MD #204. Frederick MD 21702

State Registrar 31. Date filed (Month, Dey, Year) DEC 21 2000



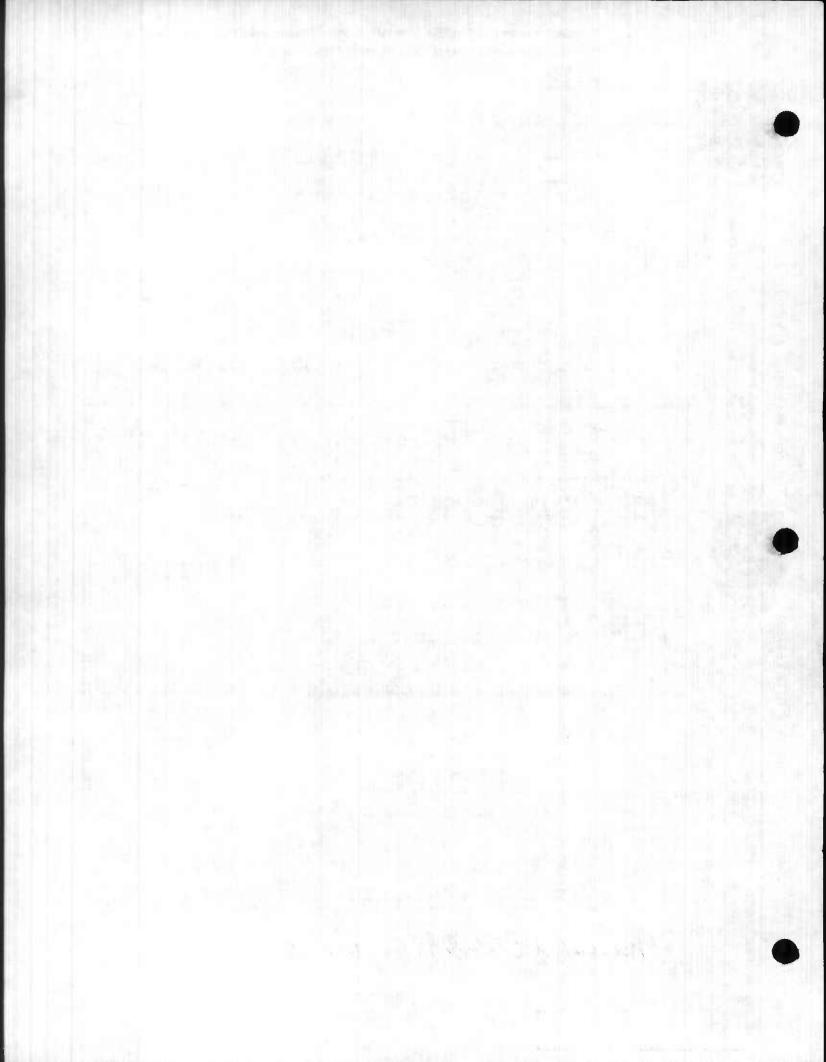


Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

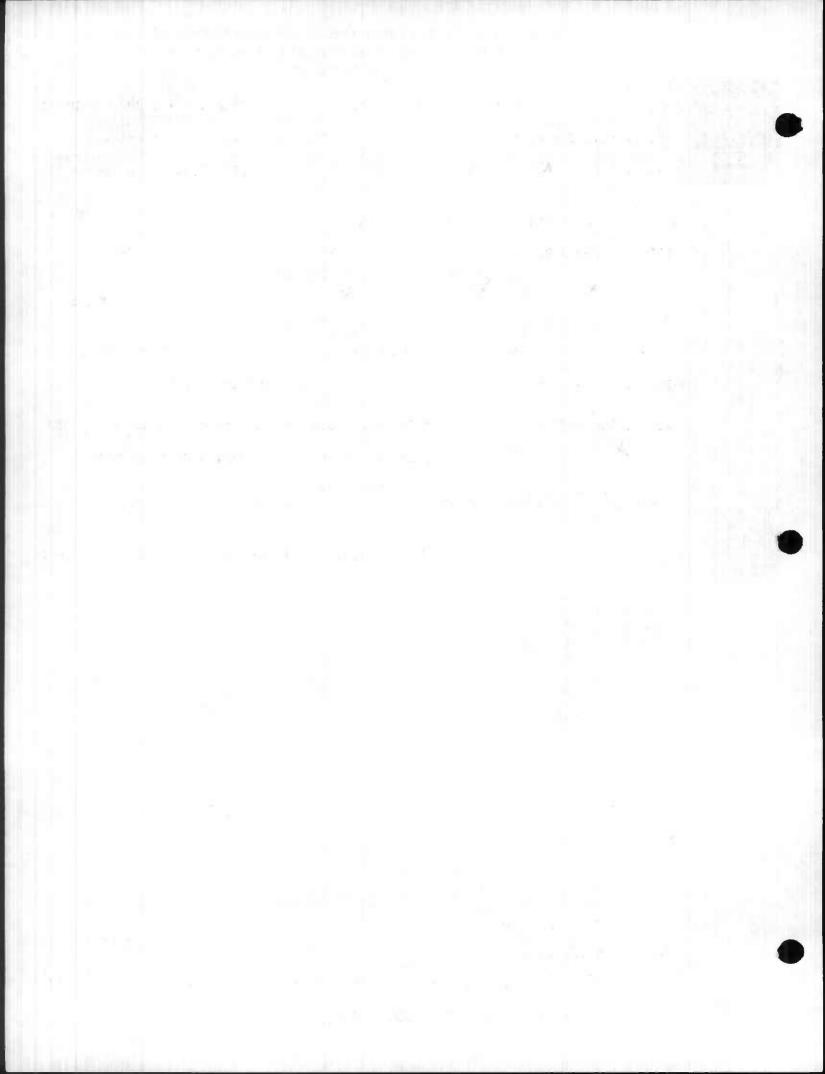
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sician	1. Decedent's Nem	e (First, Middle, La	est)			1500			2. Date of Dec	eth Dey	Year	3. Time of D		
dical	Jane C.	Reap							Decembe	-		7:15pm		
r	4e Facility Neme (/	f not institution, giv	ve street end number;)			4b. Cit	y, Town, or L	ocation of Death	4c. County	y of Deeth			
	Holy Cro 5. Social Security N 577-12-10 Usual Residence of	004		ge (In yrs. Ia		If Under 1 Months	Silveer If U Deys Ho	ver Sp nder 24 Hrs. urs Min.	8. Date of Birt (Month, De)	y, Year)		ace (State or my)		
	10a. State	10b. County		10c. City,	, Town or Loca	ation					10	d. fnside City		
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90	Maryland 10e. Street and Nur		ry	Silv	er Spr		Davida			10- Ohina 11	MATHER COLUMN	- 0		
Directo	108. Street and Nur	nber				10f. Zip C	,ode			10g. Citizen of	WHEI COUN	ryr		
2	3225 Vero	na Drive				2090				USA				
by Funeral	11. Marital Status 1 ☐ Never Merri 3 ☑ Widowed	ied 2 Merried 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2X If Yes, Give Year or Detes:	?	lt.	Yes, specify	ty Cuben, Me	xican, Puerto	pecify Yes or No- Pican, etc.)		ce - Americe ck, White, e by: White	tc.		
	/Spec	15. Decedent's E	ducation		16a. Decede	ent's Usual	Occupation	most of word	rha.	16b. Kind of B	lusiness/Ind	ustry		
Š	Elementary/Seco		College (1-4or	5+)	life. Do	O NOT use	done duning retired)	mosi or wor	ung .					
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To Be	Francis S	Colman					M	orio M	Vina					
-	19e. Informent's Ne				19h Mailing	Address /			. King	er City or Town	State Zin	Code)		
	Marie G.		Sister	last Bu	3204	Kilke	enny S	treet,	Silver	Spring	, MD	20904		
	20a. Method of Disp		Removal from Stete	000	Plece of Disposition (Neme of cemetery, cremetory or other plece)				Dete	20c. Location	Oc. Location - City or Town, State			
	4 Donetion		e of H	leaven	Ceme	terv 1	2/18/00	Silver	Sprin	o. MD				
	21. Signature of Fu	neral Service Lice	nsee							3/00 Silver Spring, MD neral Home, Inc.				
	1	Lak	77											
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	resulting in death)		e. Cancer		as e consequ				XI S			year		
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	ten	#19a, pe			10/00		inouto or	Death	1	Reg. No.			
Physic	ian	1. Decedent's Name Ralph	e (FIISI, MIQQIE	Wesle		Russum	Ιr		2. Date of De Month	er 14,	2 000	3. Time of Death 1:40 PM	
/Med Exami		4e. Facility Neme (II	f not institution		-	Kussum	, 51.	4b. City, Town, or L				1:40 PM	
Exam	ilei	11742 Bee		-				Princess			erset		
Funeral Director	_	5. Social Security No. 213-42-0	850	6. Sex 1M 2□ F	7. Age (In yr. 56	rs. last birthday) Yrs.	If Under 1 Yeer Months Days		8. Date of Bird Month, Da 01/16/	1944	9. Birthp Coun De La	lace (State or Foreig try) Ware	
show		Usual Residence of 10a. State	10b. County		10c. C	City, Town or Lo	cation		10d. Inside C				
	tor	Md.	Som	erset	P	Princess Anne		ne				1 Yes 2□N	
or 28a-f	Sire	10e. Street and Nun	nber		10f, Zip Code					10g. Citizen of \	What Coun	try?	
E 23	Ta .	11742 Be	echwoo	d Street				1853			USA		
or its	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed		12. Was De Armed 1 Tyes If Yes, 6 Year or	ecedent Ever in Forces? s 2 No Give Dates:		Vas Decedent of I f Yes, specify Cub I □ Yes 2 No	Hispanic Origin? (Sp ean, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify	e - America ck, White, o		
natur	Completed	(Speci		t grade complete	(1-4or 5+)	(Give	OO NOT use retire	during most of work	sing	16b. Kind of Bu			
Hygie ther t	ပိ	17. Father's Name (First Middle I	non	ie	Me	chanic	18. Mother's Nam	a /First Middle	Oil Fi		e Co.	
ental ked o	To Be	Ralph W.						May Reb			10)		
mari umati	-	19a. Informant's Na			4.6	19b. Mailin	g Address (Stree	t and Number or Rui			State, Zip	Code)	
perinit. rages 1 and 2 should be little with Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the M ONCE.		June Jean A.	Russum	/Wife				od Street					
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ment ant: I		4 Donetion	5 Other (Sp	ecify)	Sa	lisbury	Cremato	ry 1	2/15/00	Salisb	ury,	Md.	
Depart Import any inj once.		21. Signature of Fur	neral Service b	qicensee / ,	-		. Name end Addre	ess of Facility neral Hom	_				
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		23a Part1. Enter th				9)							
		23a 5art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.											
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State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Physician Riley 17, 2000 Virginia Dec 08:52pm /Medical 4a Fecility Nama (If not institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 42 Humbird Street Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. lest birthdey) **Funeral** Months 10 M 20 F Jan 27, MD 1923 Director 216-14-1463 Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits d 2 should be filled within 72 hours after death with the Marylan th and Mental Hyglena.

? Is marked other than "natural", or itema 23s or 28s-f show traumatic event, the West call Evantion must be notified as X Yes 2 No Director Allegany Cumberland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 42 Humbird Street 21502 USA Funeral 12. Was Decedent Evar in U,S.
Armed Forces?
1 ☐ Yes ※☐ No
If Yes, Give
Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. 1 Nevar Merried X Married 1□ Yes 2□ No Specify Specify white þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 homemaker own home permit. Peges 1 and 2 should be file Department of Health and Mental Hy importants if New 27 is marked other any injury or other transmissed other. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Simon unk 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 42 Humbird Street; Cumberland, MD21502 James C. Riley, Sr. 201 Method of Bisposition 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from State 12/20 4 ☐ Donetion 5 ☐ Other (Specify) Hillcrest Memorial Par 2000 Cumberland, MD Scarpelli Funeral Home P.A. Cumberland, Maryland 23a. Part1. Entar the disaase, or complications that causad the death. Do not anter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Immediete Ceusa (Finel disaase or condition resulting in deeth) /Medical e Chronic Obstructive Pulmonary Disease years Examiner Due to (or es e consequence of). Physician/Medical Examiner shysician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events rasulting in death) Last Due to (or es e consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Box 68760 Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings aveilable prior to completion of ceuse of death? 24a. Wes en eutopsy Completed To the Hospital or Attending Physician: The law within 24 hours after death.

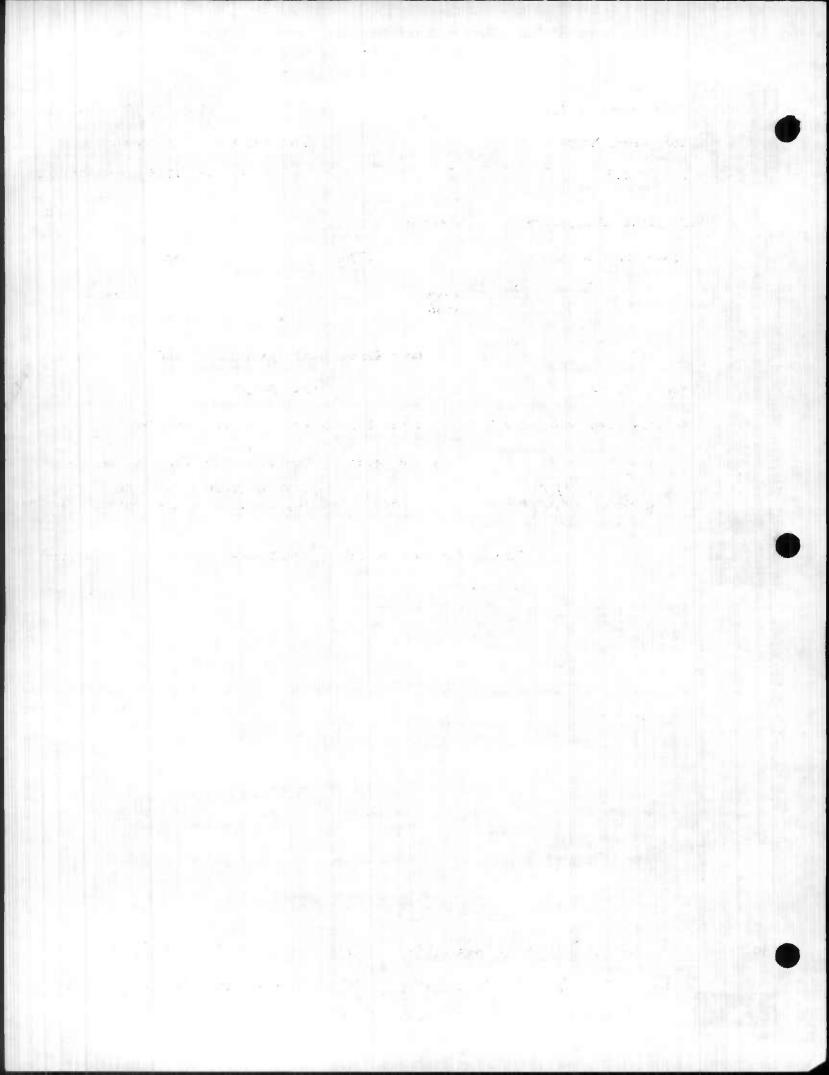
To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2: 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vitai 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Dey Year) Menner of Deeth 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifiar edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. one) 29d. Date signed (Month. Dav. Year) 29b. Signeture ar 29c. License number D09157 Dec 18, 2000 fress of person who of impleted cause of death (Item 23a) (Type, Print) Snow M.D. 124 W. 3rd Street Cumberland MD 21502 Paul 3 DEC 1 9 2000 (Marily 2000) 32. Registrar's Signatura Registrar

DHMH 16 Rev 6/95

050 19 200

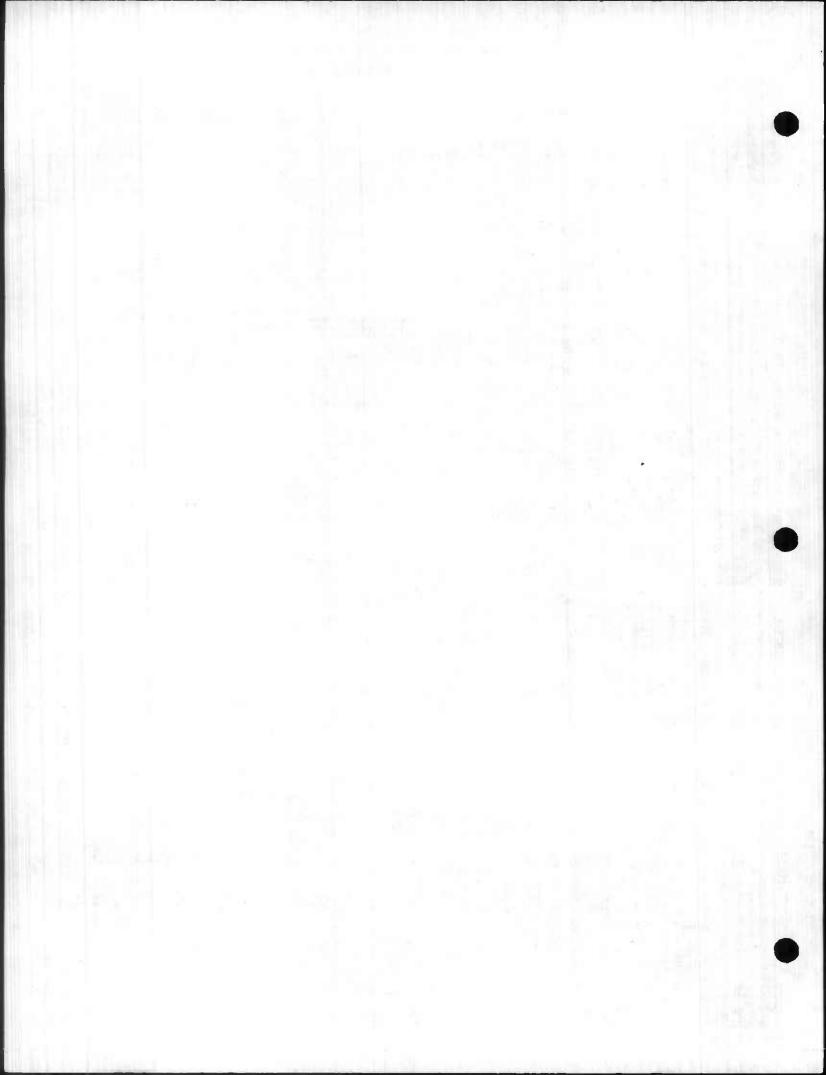
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			Ce	ertificate o	f Death	F	Reg. No.				
Discortation	1. Decedent's Name (First, Middle, Las	st)	2019105			2. Dete of Dee Month	th Dev	3. Time of Death Yeer			
Physician Medical Examiner	James Robert Swin				4b. City, Town, or	December Location of Deeth	,	2000 2:24 am			
Examiner	Holy Cross Hospita				Silver S	nrino	Montgo	merv			
Funeral			yrs. last birthday) If Under 1 Yes	ar If Under 24 Hrs	8. Date of Birth		Birthplece (State or Foreign Country)			
Director	233-30-6608 Usuel Residence of Decedent	4 M 2 □ F	M 2□ F 77 Yrs. Months Deys Hours Min. (Month, Day, Year) Col. Aug 11, 1923 Wes								
/anyland	10a. Stete 10b. County		ocation			10d. Inside City Limits 1 ☐ Yes 2 ☐ No					
the N	Maryland Montgome	ery v	Vheaton	10f. Zip Code			10g. Citizen of Whet Country?				
filer death with the Maryla flems 23s or 28s-f sho strat must be nouried at Funeral Director	11419 Sherrie Lan	e		20902			USA				
020 urs a urs a by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		1943- 1946	Wes Decedent of If Yes, specify Co	f Hispanic Origin? (Suban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rece Bleck Specify.	o-American Indien, k, White, etc. White			
21215-0020 ed within 72 hours at ygiene are your than "netural", or fr. the Medical Examination Completed by F	15. Decedent's Ec (Specify only highest gre Elementery/Secondary (0-12)	ducation	16e Dece	edent's Usuel Occ e kind of work don DO NOT use reti	cupation ne during most of wo ired)	orking	16b. Kind of Bu	siness/Industry			
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Maryland d 2 should be file th and Mantal Hy T la marked othe traumatic event	Robert Swink				Bess Pr						
aryla should nd Mar marks umatic	19a. Informent's Neme/Reletionship (Type, Print)	19b. Mail	ling Address (Stre	et end Number or R		r, City or Town,	Stete, Zip Code)			
Md 2 and 2 27 is or trau	Dorothy Frances Sy				ie Lane,						
other tr	20e. Method of Disposition	2	20b. Place of Disp	osition (Name of	10001	Dete		City or Town, State			
0 0 0 7	1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	farvland	Veteran	's Cemete	12/22 ry 2000	Crownsy	ille, MD			
Baltimoperant: Pag Department Important: it any injury o	21. Signeture unerel Service Licen		2	22. Name end Add	dress of Fecility						
Ball permit Depa Impo any fr	Do Shert Vy	Inc.									
Physician	23a. Part1\Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	deeth. Do not er	nter the mode of d	lying, such es cardia	c or respiretory en	rest,	Approximete Approximete Intervel Between Onset end Death			
/Medical Examiner	Immediate Cause (Finet disease or condition resulting in deeth)	a Chronic C	bstruct	ive Pulm	onary Dis	ease		10 years			
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nsit ted		b. Asbestosi						25 years			
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Box Beath cer attendir of for use	Doe it Other significant and distance			OOF DIA	-b	stribute to the cause of death?					
ds, P.O. Box uiras that the death certi signed by the attending tid be detached for use a d by Physician/M	Hypertension	ontributing to death but no	underlying cause		res 2□ No	3⊠ Probably 4□ Unknown					
Di S S Di						24a. Was o	en eutopsy med?	24b. Were eutopsy findings available prior to completion of ceuse of deeth?			
						1 U Y	es 2 No	1 ☐ Yes 2 💢 No			
Vital I hicken: The certificata rector, pag	25. Wes case referred to medicet exeminer?				26. Plece of De	eth (Check only o	ne)				
n of ng Phys fter this uneral di	1 Yes 2 No 27. Manner of Deeth 1 Netural 5 Pending	28a. Date of Injury (Month, Day Ye	2 ER/Outpetie	of 28c. Ir	jury et Vork?	Home 5 Resid	lence 6 Other				
Attending and death.	2 Accident investigation 3 Suicide 6 Could not be		At home farm e		☐ Yes 2☐ No	28f Location (S	Street and Numb	er or Rural Route Number,			
Division (tal or Attending P ts after death. al Director: After t led in by the funers Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)	treet, rectory, onk		City or Tow	m, Stete)	or a rate resident and a			
Divisio To the Hospital or Attandi within 24 hours attandeath. To the Funeral Director: A completaly filled in by the fi	29a. Certifier 1 X Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of moniner: On the basis of exa and manner steted.	aminetion end/or i	th occurred et the nvestigetion, in m	time, date end plec y opinion, deeth occ	e, and due to the durred et the time,	cause(s) and ma date end place, e	nner es stated. and due to the cause(s)			
within Vithin Complex Complex Me	29b. Signeture end title of certifier	No		29c. Lice	ense number		29d. Date signed	(Month, Dey, Year)			
10	Da Co Co Co	Lad Its 6	MA	M	35608	7	12/2	10/00			
	30. Name end eddress of person who	completed ceuse of death	(Item 23e) (Type	p, Print)	23603	,	7 10				
	Elizabeth	L. Wi	Nter		Forest Gle	en Road,	Silver	Spring, MD			
State Registrar	31. Dete filed (Month, Dey, Year) DFC 9 1 26	32. Registrer's	Signeture 4	book							



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al	AVE I S NO THE S						Decembe			8:05 pm
						4b. City, Town, or L	ocation of Death	4c. County		
	Genesis Elder					Silver Sp		Montge		
	5. Social Security Number	6. Sex 7	Months Devs Ho				8. Date of Birth (Month, Day,	Year)	9. Birthplace (State or Fore Country)	
007-20-5400 PLIM 2LIF 78 Yrs. Usuel Residence of Decedent							Mar 30,	1922	New	York
	10e. State 10b. Cour	itv	10c. City	Town or Loc	cation				1	0d. Inside City Limits
2									- '	1 ☐ Yes 2 🗓 No
	Maryland Montg	omery	Silv	er Sp:	1					
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	1 Never Married 20 M	If Yes, Give		1	☐ Yes 2) No	Specify:		Specify	. Wh	ite
-	3 Widowed 4 Divord		les:					10) 10 1 15		
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Ì	Elementary/Secondery (0-12				DO NOT use retire			Corre	non+	
	17. Father's Name (First, Midd	4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4 (4		rerso	nnel Man	18. Mother's Nem		Governi taiden Suman		
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	19e. Informent's Neme/Reletic			19b. Meilin	g Address (Stree	t end Number or Rui	al Houte Number,	City or Town,	State, Zip	MD 2090
	Alta Lee Steam	ns / Wite	non Die	3429 1	South Le	isure Wor				
	20e. Method of Disposition 1 ☐ Buriel 2XX cremation	n 3 🗆 Removel from S		netery, crem	netory or other pla			20c. Location -		
	4 Donetion 5 Other	(Specify)	Metr	opoli	tan Crem	atory l	2/21/00A	lexand	ria,	VA
	21. Signature of Feneral Servi	on Licenses		22. F	Name end Addr	ess of Fecility Collins	Funeral	Home	Tnc	
	VASONTX	IX her by								MD 2090
23a. Pent). Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, show, or heart failure. List only one cause on each line.										Approximete Intervel Between
	SHOWN, OF FIGURE L	st only one cause on ee	on me.						1	Onset end Death
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	resulting in deeth)	Ө	Due to /or s	es a consequ	neuca ott.				10	~ days
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Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): d										
		d							<u> </u>	
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							1 □ Ye	s 2 No	10	Yes 2 No
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1	1 Yes 2000	1 L In		R/Outpatient	3LI DOA		ome 5 Reside			y)
	27. Menner of Death 1 Neturel 5 ☐ Pen	aning .	Injury 2 Dey Year)	28b. Time of Injury	28c. fnju Wo		28d. Describe ho	w injury occur	Det	
		stigetion d not be]Yes 2□No	00/ 1			10-4-11
	4 Homicide dete	mined Zoe. Place	of tnjury - At hom g, etc. (Specify)	ne, ferm, stre	eet, fectory, office		28f. Location (St. City or Town	reet and Numb , Stete)	oer or Aure	u rioute Number,
1			11-113							
	(Check only 2 Medic	ring Physician: To the b at Examiner: On the bas	als of examinetio							
	one)	end menne	er steted.							
	29b. Signature and title of cert	lier OO	00	0.0		se number	-	9d. Date signe		
1	- Huer	allu	elle	MI	D	3826	2 1	Decous	Bois	20 2000
١	30 Name and address of pers	n who completed cause	of death (Item 2	23a) (Type, F	Print)	10.60				000
	OU. HOUSE ONLY AUGIOSS OF POIS	in		400				0		0 a (V) ()
	De A Mond	vivallo d	2401	Poss	aval-	BUND C	10 to 20	io kn	CREN	NO 2-05
	Dr A Mond 31. Date filed (Month, Day, Ye	our wid	gistrer's Signatu	Rese	Look	BLVD S	ueto 3	io Ro	chir	lle 25850



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year **Physician** Stella Stathopoulos aka Stella Stevens December 14, 2000 1:37PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 4701 Willard Ave. #622 Chevy Chase Montgomery If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F Deys Director 80 15, 1920 578-46-1361 Greece Usual Residence of Deceder 10a Stete 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 4701 Willard Avenue, #622 Funeral United States 20815 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indien. 11. Meritel Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Illed within Elementery/Secondery (0-12) College (1-4or 5+) Hygiene 12 Private Secretary Membership Organization 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be III ment of Health and Mental H ant; If them 27 is marked off jury or other traumstic even 86 Lo John Stathopoulos Emily Garbidakis 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Harry A. Calevas/Attorney 20816 4701 Sangamore Road, Bethesda, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removel from State Dec. 22 4 Donetion 5 ☐ Other (Specify) ncoln Cemetery 2000 Brentwood, Maryland
22. Name and Addrass of Facility Robert A. Pumphrey Funeral Home/ Ft. Lincoln Cemetery 21. Signetu and Ineral Service Licensee Bethesda-Chevy Chase, Inc. 75

Bethesda, Maryland 20814-3501

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 7557 Wisconsin Avenue Approximete Interval Between Onsat and Daath **Physician** /Medical Immedieta Causa (Final diseese or condition resulting in deeth) Acute Cardiac Arrythmia Examiner Due to (or es a consequence of): Examiner 20 Years Cardiomyopathy certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequence of): 20 Years Hypertension Box 68760 Physician/Medical Due to (or es e consequence of): resulting in death) Last 88 189 I for o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown signed t Records, by 24b. Were eutopsy findings aveileble prior to 24a. Wes en eutopsy performed? Completed completion of causa of deeth? certificate hes birector, pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred After ! Certification: Attending 1 Naturel 5 Pending Invastigation deeth. 1 Yas 2 No 2 Accident Hospital or Attend 24 hours after deeth Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) NO U 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and menner stated. 29a. Certifier edical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of ourtille 6 D0052247 December 15, 2000 NO

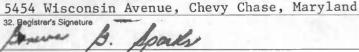
State Registrar

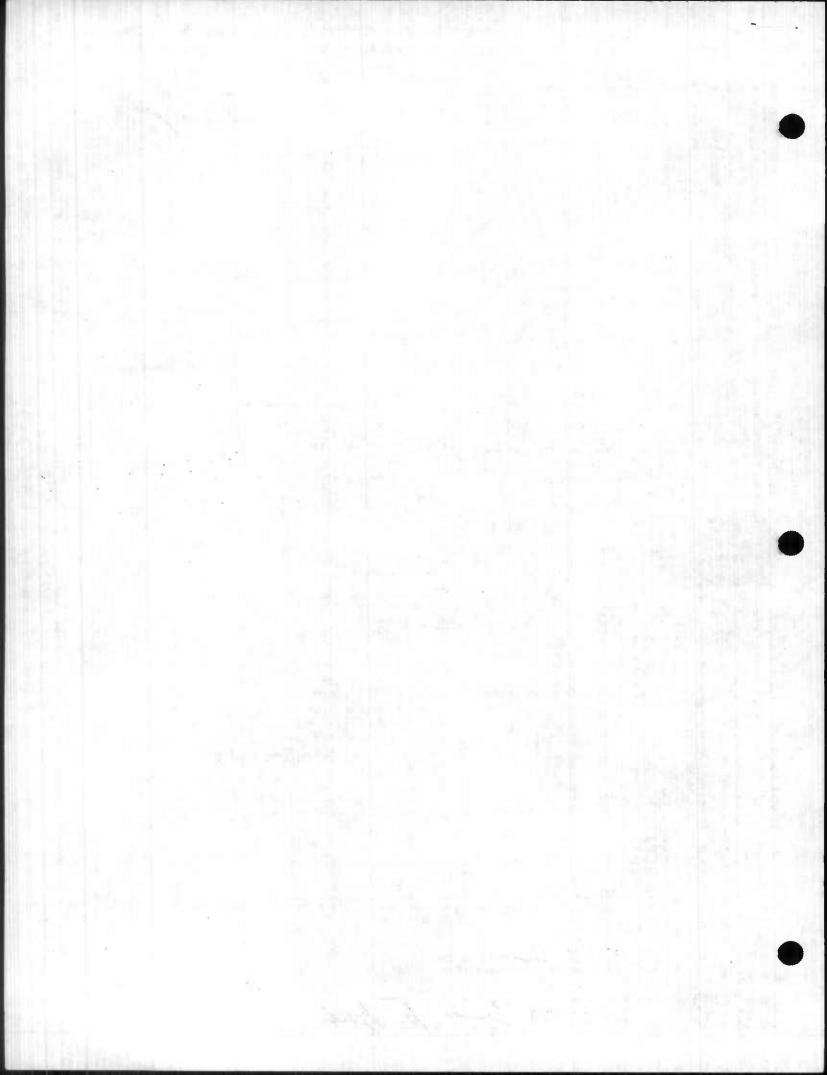
DEC 2 2 2000

Collin Cullen, M.D.

31. Dete filed (Month, Day, Year)

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)





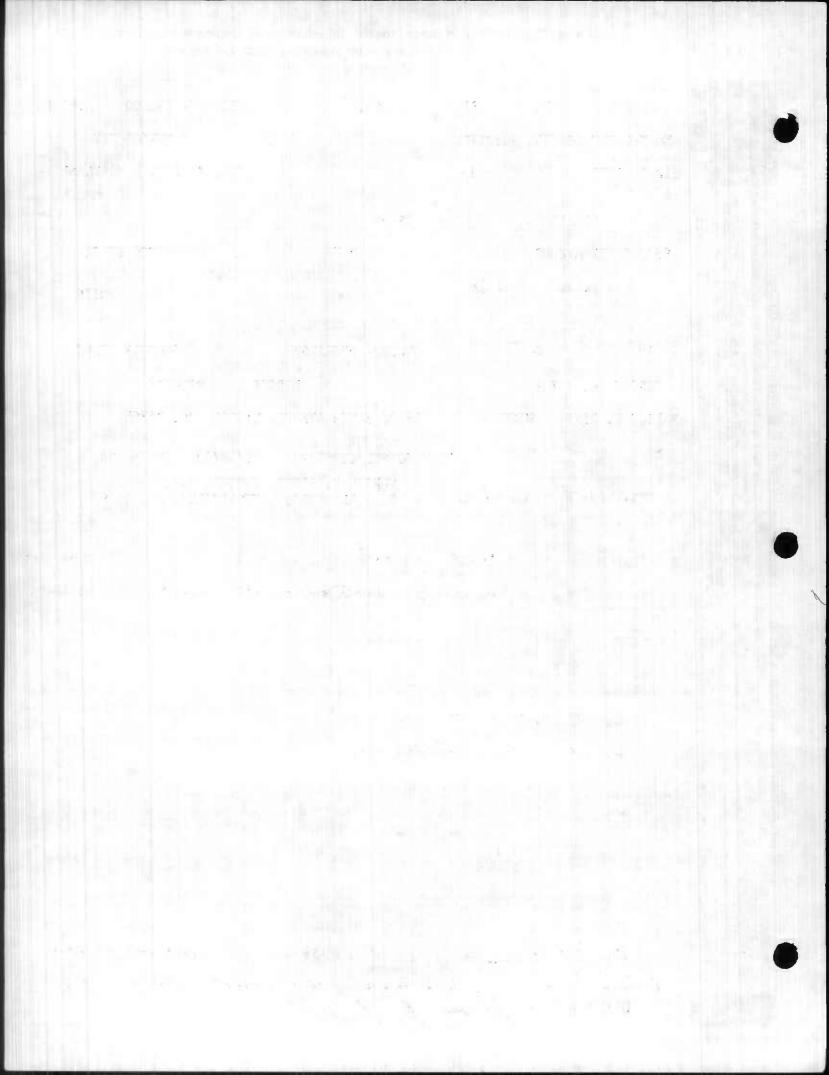
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 0 4 2 2 2 1

			Certifica	te of Death	Re	g. No.	46664			
Physician	Decedent's Neme (First, Middle, Last				2. Dete of Death Month	Dev Y	3. Time of Dea			
/Medical	JASPER LE		SR.		DECEMBE					
Examiner	4a Fecility Neme (If not Institution, give			4b. City, Town, or	Location of Deeth	4c. County of				
	MONTGOMERY GENER		to a bish do al. If I lod	OLNEY er 1 Year If Under 24 Hrs	O Data of Birth	MONTGO				
Funeral Director	5. Social Security Number 6. Se 212 30 6672	7. Age (In yrs. 69	Yrs. Month			,1931	Birthplece (State or Fo Country) MARYLAND			
P & =	10e. Stete 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Li			
28a-f show	MD. HOWARD		LISBON				1 □ Yes 21⊠			
	15939 SOUTH AVENU	E		21765		g. Citizen of Who				
if, or its	11. Merifal Stetus 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 □ Yes	edent of Hispenic Origin? (Secify Cuben, Mexicen, Puer 2 No Specify:			American Indien, White, etc. WHITE			
tal Hygiene. 4 other than "natural; went, to welcon Exercise. Be Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed)	16e. Decedent's Us (Give kind of y	uel Occupetion work done during most of wo use retired)	rking	6b. Kind of Busin	ness/Industry			
within sene.	Elementary/Secondary (0-12)	College (1-4or 5+)		OPERATOR		GROCERY	STORE			
C Ret	17. Fether's Neme (First, Middle, Last)	0	OWNER -		me (First, Middle, N		STORE			
d bental he does	JESSIE M. SIR	K		BESSI		TCHIE				
aumatic event,	19a. Informent's Name/Relationship (T)		19h Malling Addre				ete Zin Code)			
and 2 s a alth en n 27 is i	MARION E. SIRK,	WIFE	15939 SO	UTH AVENUE, I	umber or Rurel Route Number, City or Town, State, Zip Code) NUE, LISBON, MD. 21765					
permit reges 1 and 2 should be hied winn Dependment of Haalth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, it is wone. To Be Compi	20e. Method of Disposition 1 3 Buriel 2 Cremation 3 F 4 Donetion 5 Other (Specify)	temoval from State	Place of Disposition (No cemetery, cremetory of UE GOSPEL	other place)	Dete 2 12/19/00		MD.			
Departs Imports any inju	21. Signature of Funeral Service Licensee MURIEL A. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD.									
	23a. Pert1. Enter the diseese, or compl shock, or heart failure. List only o						Approximete intervel Between			
hysician	Shook, or heart failure. List only o	ie ceuse on eeus iine.					Onset end Deat			
/Medical	Immediate Cause (Finel disease or condition	1. 46.	STROKE				09 Har 111 0			
xaminer	resulting in death)		or es e consequence o				20 44 W			
physician and street the bunal-transit edical Examiner		crons	I INTRA	elsessur.	Honors 4	Arts	2 con INUT			
g physician and es the burial-transit	Sequentially list conditions,	Due to (c	or es e consequence o							
physician and street trains the bunal-trains edical Example 1	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury									
sata c	that initiated evenfs resulting in deeth) Lesf	Due to (o	or es e consequence of):						
0 9 5		ı								
trend or us										
vequinas traume ceau been been signed by the attending should be datached for usa e leted by Physician/M	Pert II. Other significent conditions con	tributing to death but not res	sulting in the underlying	ceuse given in Pert I.	23b. Dld to	ecco use contr	ibute to the cause of de			
d by	ole let	12141112A Holan	March		1 🗆 Ye	s 2⊠No 3	Probably 4 Uni			
signer bed	- Maryon o	ATRIA GA	ne centre				- 45 W			
ceta has been s paga 2 should	CAMPME	ATKIA GO	BRULATIO	V	24e. Wes er perform		 Were eutopsy finding eveilable prior to completion of ceus 			
has b	011/00/10						of deeth?			
pag pag					1 □ Ye	s 2 No	1 ☐ Yes 21☑ No			
s certificeta ha director, paga	25. Wes case referred to medical exeminer?				ath (Check only one)				
this co	1 ☐ Yes 2 ☑ No		YER/Outpetient 3□ I		Home 5 Reside					
After t funera tion:	27. Menner of Deeth 1 Naturel 5 Pending	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe ho	w injury occurred				
Attending Physician: ordeath. ector: After this certific by the funeral director. iffication: To Be (2 Accident investigation		М	1 ☐ Yes 2 ☐ No						
五年 三	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (St. City or Town	eet and Number , State)	or Rural Route Number,			
within 24 hours after dash. To the Funeral Director: After the completely filled in by the funeral Medical Certification: 1		Bicien: To the best of my knoner: On the basis of examina end menner stated.								
Within ompl	29b. Signeture end title of certifier		2	9c. License number	25	d. Date signed (Month, Dey, Year)			
	611	1		OrVaine	0	6.1 .6	· · · · ·			
2	20 Noment Level / w	Cer mm	- 02e) (T 2 : ::	025949 000 COURT SU	V	umstre	15,000			
	30. Name end eddress of densen who co	empleted cause of deeth (Item	n zsa) (Type, Print)	- a lovar	720 4	· · · · · ·	24.772 2			
State	31. Dete filed (Month Day, Year)	32. Registrer's Signa	ature	out and so	11/1 - 10	in how	70172			
Degistran	DEC 1 8 200	Denever	A L	10. M.						



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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day Year **Physician** JOSEPH ROBERT SILVERMAN DEC. 16 2000 5:15 PM /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 110 M 2□ F 022-26-7884 Yrs. 64 JULY 31,1936 Director MASSACHUSETTS Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Nes 2 No Director MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code "natural", or items 23a or 14405 TARPON TERRACE 20905 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No II Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. filed within 72 hours after. Hygiene. Wher than "natural", or ite 1 ☐ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1960-62 WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry GEORGE WASHINGTON Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Depertment of Heelth and Mental Hygiens important: if Item 27 is marked other tha any Injury or other traumatic excess. UNIVERSITY 5+PROFESSOR OF ENGINEERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 JACK DAVID SILVERMAN NORMA ILLMAN 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) HEDDA SILVERMAN/ WIFE 4405 TARPON TERRACE, SILVER SPRING, MD 20905 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 12/18 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 2000 OLNEY, MD 21. Signeture of Funeral Service Licanses 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) SMALL LYMPHOCYTIS LYMPHOMIA 6 MONTHS Examiner Due to (or es e consequence of). Examiner attending physician end for use es the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical Due to (or as e consequence of) signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? should should 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certific funeral director 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, larm, street, lactory, office building, etc. (Specify) 8 4 Homicide 24 hours 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.

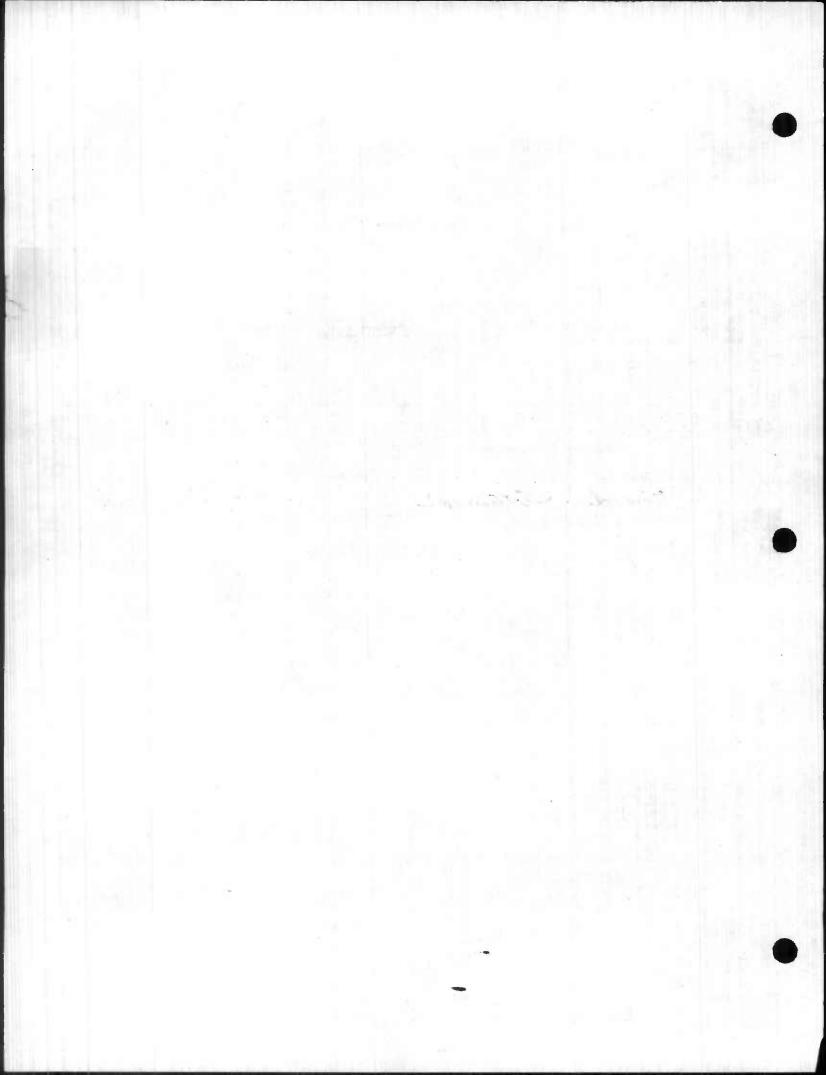
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end menner stated. To the Hosp within 24 hou To the Fune completely fil 29a. Certifier 29b. Signe and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) mo DECEMBER 17, 2000 2 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) RALPH V. BOCCIA, MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 20

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month **Physician** 15, 2000 Judith Ann Sheahin December 8:10 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Holy Cross Hospital Silver Spring Montgomery 8. Deta of Birth (Month, Day, Year)
Jan. 15, 1945

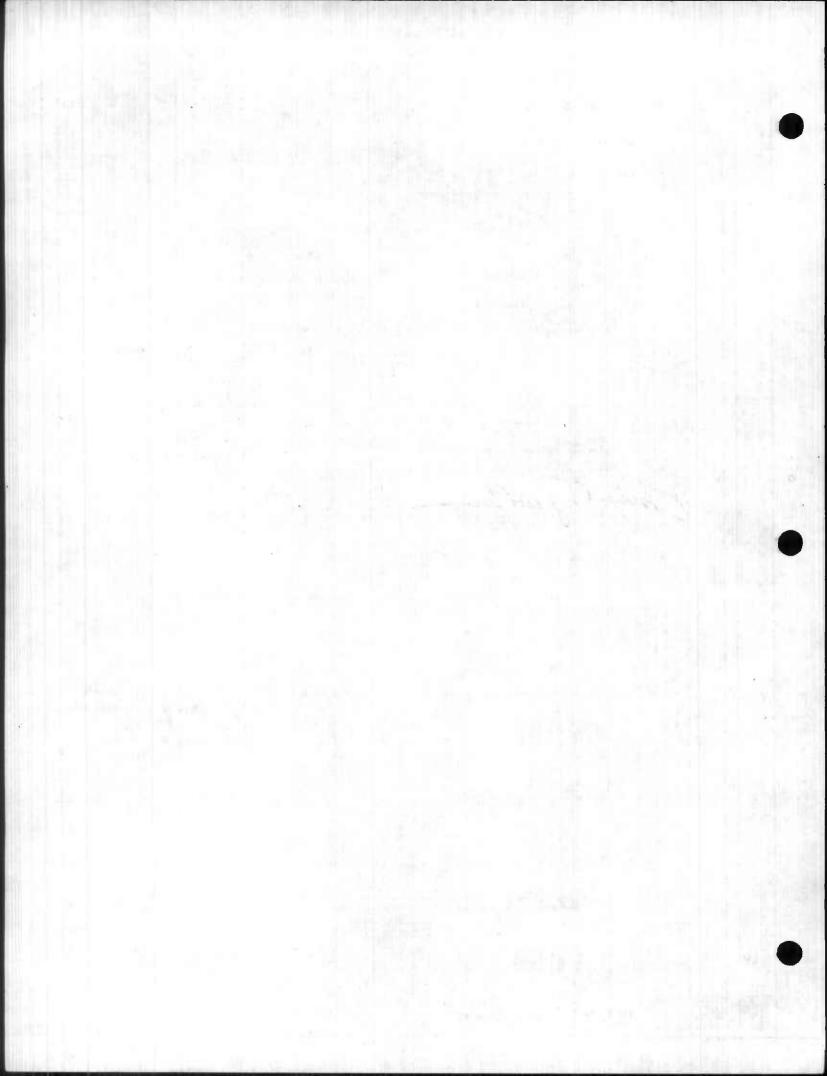
8. Birthplece (State or Foreign County)
Washington, DC 5. Social Security Number 7. Age (In vrs. last birthday) If Undar 1 Year | If Under 24 Hrs. **Funeral** Months Deys 1 M 2 F Hours 55 Director 579-56-1802 Usuel Residence of Decedent the Meryland 10c City Town or Location 10e State 10b. County 10d. Inside City Limits d other than "natural", or hems 23s or 28s-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☒ No Director Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20814 USA 11 Maplewood Park Court Funeral e filed within 72 hours after death all Hygiene. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Yeer or Detes: 1 ☐ Yas 2 ☑ No Specify Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Health Technician P.G. County Schools permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe eny injury or other treumatic event, bings. 18. Mother's Neme (First, Middle, Maiden Surnema) 17. Fathar's Nama (First, Middla, Last) Ivey Heffner John Crovo 10 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 11 Maplewood Park Ct., Bethesda, Maryland 20814 George Sheahin / Husband 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/19/00 Silver Spring, MD 21. Signature of Funeral Sergice Liver) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland of plications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, nly one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Metastatic Breast Cancer to Lungs, Bone, Liver disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner ettending physician and for use es the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immadiata cause. Enter Underlying Ceuse (Disease or injury that initiated avents Due to (or es a consequence of): Box 68760 Physician/Medical Dua to (or es e consequanca of): resulting in deeth) Last signed by the e Pert II. Other stanificant conditions contributing to death but not resulting In the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ The law requires 24b. Were eutopsy findings aveileble prior to been si 24e. Wes en eutopsy performed? Completed completion of cause of deeth? page 2 1 ☐ Yes 2 No cartificata Division of Vital Physician: 25. Wes case referred to medical examiner? director Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Lo 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 ₩ Neturel 5 Pending invastigetion 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier na December 16, 2000 10 D05937 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20902 2101 Medical Park Drive, Silver Spring, Maryland Robert Kramer, M.D.

State Registrar

31. Dete filed (Month, Day, Year) DEC 2 1 2000

32. Registrer's Signeture souks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month Vear Schwartz Sylvia DECEMBER 19, 2000 9:30 AM 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SPRING HOUSE BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Deys 1□ M 21 F 109-16-7397 84 JAN. 18, 1916 NEW YORK Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MONTGOMERY BETHESDA 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 4925 BATTERY LANE 20854 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ** Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puarto Rican, atc.) 14. Race - American Indien. 11. Marital Status Black, Whita, atc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION 5+ COORDINATOR FOR A COLLEGE 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) MAX STUCHIN SOPHIE LEHRMAN 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 65 TROY DRIVE, SHORT HILLS, NEW JERSEY 07078 JUDITH DUBERSTEIN/DAUGHTER 20b. Place of Disposition (Nama of cemetery, cremetory or other plece) 20e. Method of Disposition DEC 22 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) B'NAI ABRAHAM MEMORIAL PK 2000 UNION, NEW JERSEY 21. Signeture of Funeral Service Comme 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Finel disease or condition resulting in death) 6 weeks ancimoma Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Dua to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Insufficience 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospitel: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

burial-transit death certificate be execu Box 68760. the 980 P.0. signed by t Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Examiner Physician/Medical þ Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

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b Вати 23а

natural, or

Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H lant; if flem 27 is marked off

Physician

/Medical

Examiner

72 hours after

Baltimore, Maryland 21215-0020

Director

à

Completed

Be

MD

27. Manner of Death 2 Accident 3 Suicide 4 Homicide

29a. Certifier (Check only one)

5 Pending investigation 6 Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of

28c. Injury et Work? 1 Yes 2 No 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at tha tima, data end place, end due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and menner stated.

29b. Signature and titla of certifian

29c. License number 2051 29d. Date signed (Month, Dey, Year) 00

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

Scott ohen 31. Date filed (Month

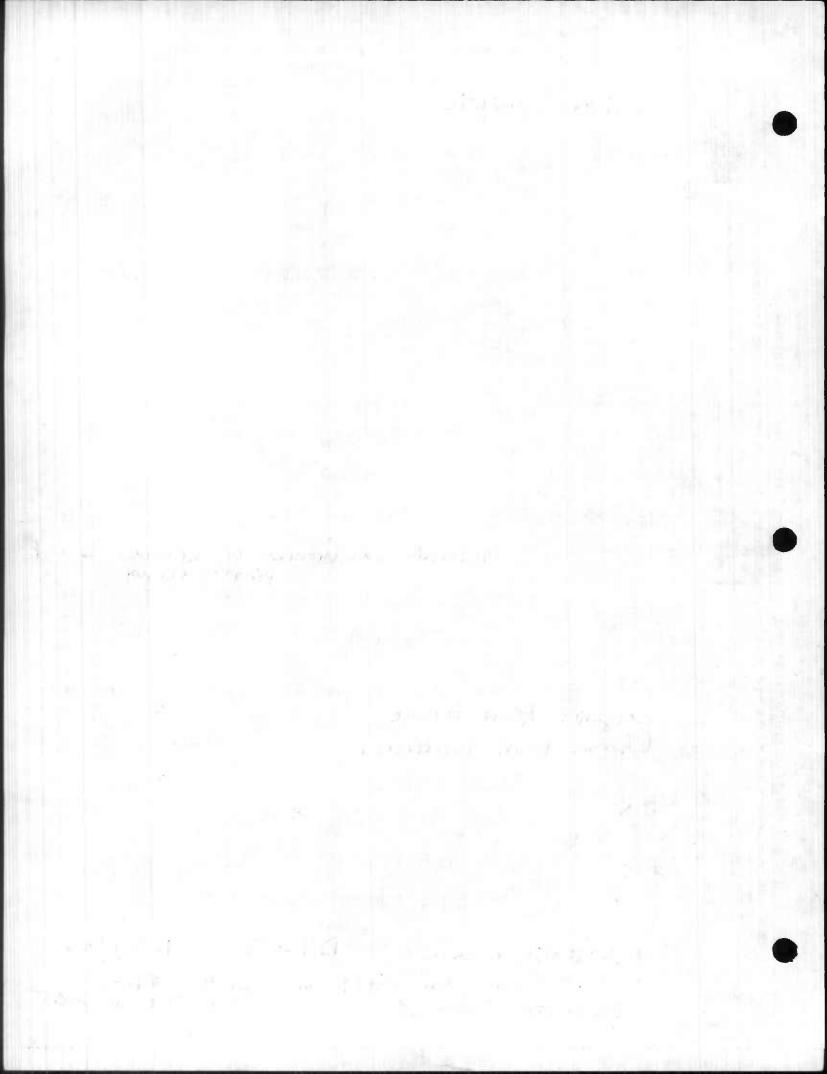
32. Registrer's Signeture

MD

Wiscompa Ave #1125 Chery Chase MD 20815

State

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 2228

					Certificat	te of	Death	R	eg. No.	-7 C				
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/Medica Examine		4e Facility Name (If not institution, give	street end number)				4b. City, Town, or L		4c. County					
	ų	HEARTLAND NU	RSING HOM	E			HYATTSVI	LLE	PR	INCE	GEORGES			
Funeral Director		5. Social Security Number 6. S 486-30-5645	ex 7. Ag M 2□ F	ge (In yrs. last I 72	Yrs. If Under	Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, SEPT.	Year) 9,1928		lece (Stete or Foreigr try) ISSOURI			
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D 5 74	by	3 ☐ Widowed 4 🌡 Divorced	If Yes, Give Year or Dates:	If Yes, Give 1951-		2 No	Specify:		Specify		TTE			
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/Medical		Immediate Cause (Final disease or condition	ChR	onic	Mos	thu	ctive	ung Disease year						
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The law ste hes bege 2 s	Completed									lo of	death?			
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D & & 9	2	1 Yes 2 No	1 🗀 Inpate	-	Outpatient 3 D	OA	4 Nursing H	ome 5 Reside			y)			
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Lor Attending after death. Director: After din by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		turn. As branch	M		Yes 2 □ No	28f Legation (S	troot and Alumi	har or Pur	el Route Number,			
or An intercent	Certification:	4 ☐ Homicide determined	200. Flaud UI III	ic. (Specify)	farm, street, facto	у, опіса		City or Town		oer or nure	" House realities,			
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		30. Name and address of person who	completed cause of c	Death (Item 23s	(Type, Print)	n 20 10	10. DI	11 +		MA	19 2000			
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State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Vijay Paul Sathya

Physician	
/Medical	
Examiner	

Funeral

Director

23s or 28s-f Nerna

Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiens. Int. If Hern 27 is marked other than "natural", or Ne Maryland 21215-0020 Baltimore, Dopartment I

Physician /Medical Examiner

Box 68760.

P.O.

Records,

Division of Vital

The law requires that the death certificate be executed and burial-tran the USB as is centificate has been signed by director, page 2 should be detact this certificate has or Attending Physician: completely filled in by the funeral After deeth. s after deeth

December 17, 2000 5:00 AM 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges 8. Data of Birth (Month, Day, Year) Aug. 9, 19 If Under 1 Yaar | If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Days Hours 1₩ M 2□ F Yrs. 35 229-06-2957 1965 India Usual Rasidence of Dacadent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2€ No Directo Prince Georges Maryland Hyattsville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4123 Olivet Street 20783 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, White, etc. 1 XYas 2 No If Yas, Giva 1 ☐ Nevar Married 2 🗓 Married 1 Yes 2 No Specify: Specify. p 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 1984 Asian Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Building HVAC Technician 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surneme) Be 2 Paulraj Sathyasheelappa Saroja P. Abnes 19a. tnforment's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Angela M. Sathya / Wife 4123 Oliver Street, Hyattsville, Maryland 20783 20b. Place of Disposition (Neme of cematary, cramatory or othar place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, State 1 Buriai 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) George Washington Cem. 12/20/00 Adelphi, Maryland 22. Nama and Addrass of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Sarvice Lie 11800 New Hampshire Avenue ach Silver Spring, Maryland the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on such line. Approximata Intarval Batween Onsat end Deeth disaasa or condition rasulting in daeth) Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaase or injury that initiated evants rasulting in daath) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 22 No 1 Yes 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) T Yes Medical Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data and plece, and due to the cause(s) end mennar es stated.

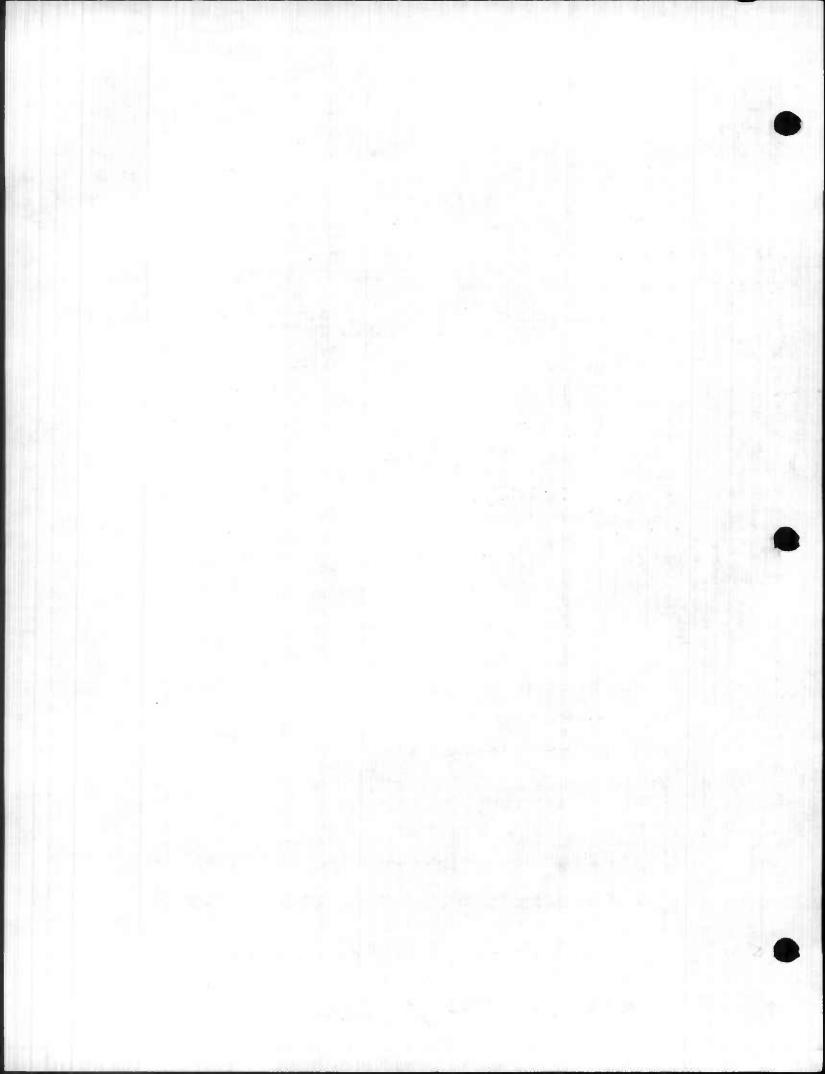
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stetad. 29a. Certifian (Check only one) 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and title of certifian 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) James Catavenis, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Data filed (Month, Pay, Year) DEC 2 1 2000

To the Hospital within 24 hours a To the Funeral D

32. Degistrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. AMEND ITEM#5 PER F.H. G808 1-25-02 JAB 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month Year SACKETT 8256 HNNE 12 15 -2000 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GEORGES HOSPITAC CENTER CHEVERLY PRINCE GEORGES If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) If Under 1 Yaar 5. Social Security Number 6. Sex Birthplaca (Stata or Foreign Country) 096-20-73186 1 M 2 XF Months Days Jan 25, New York Usuel Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Prince George's Maryland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 USA 12904 Bently Lane Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forcas? Bleck, White, etc. 1 ☐ Yas ②☐ No If Yas, Giva 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Henery Breen Anne Kennedy 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Donna E. Sackett/ Daughter 1223 Massachusettes Ave., SE, Washington, DC 20003 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 Crametion 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 12/21/00 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. Ch 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) GROUP A STREPTOLOCCUS BACTEREMIA 3 DAYS Dua to (or as a consequence of) SEVERE E PISTAXIS Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE PULMONARY DISEASE 24b. Wara autopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy performed? CORONARY 2 No 1 Yas 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

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25. Was casa ratarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 27. Mannar of Daath 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 ☐ SuicIda 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Ptace of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and mennar stated. 29a. Cartifier (Check only one) 29b. Signatura and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year)

30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

SUITE 204 7500 HANOVER

12-15-2000

MD 20770

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LEIGHTON FURRESTER MD

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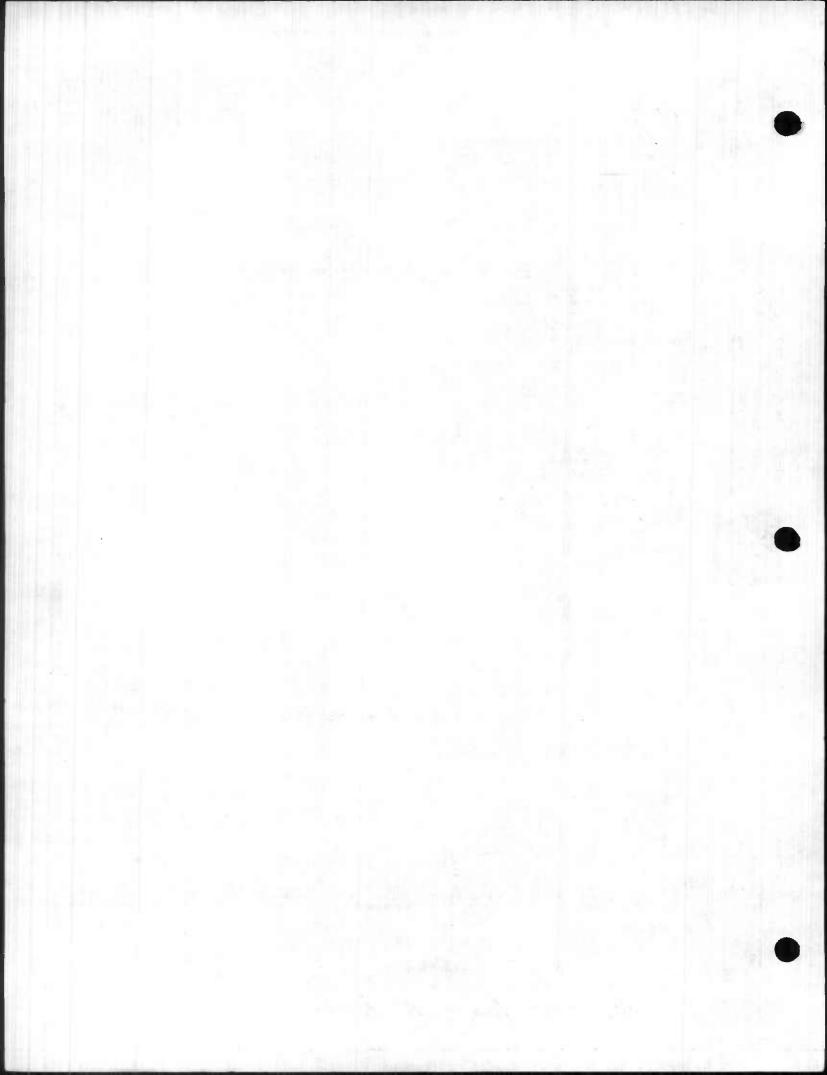
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32. Régistrar's Signatura PROSER

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Registrar



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State

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Qamar U. Zaman 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

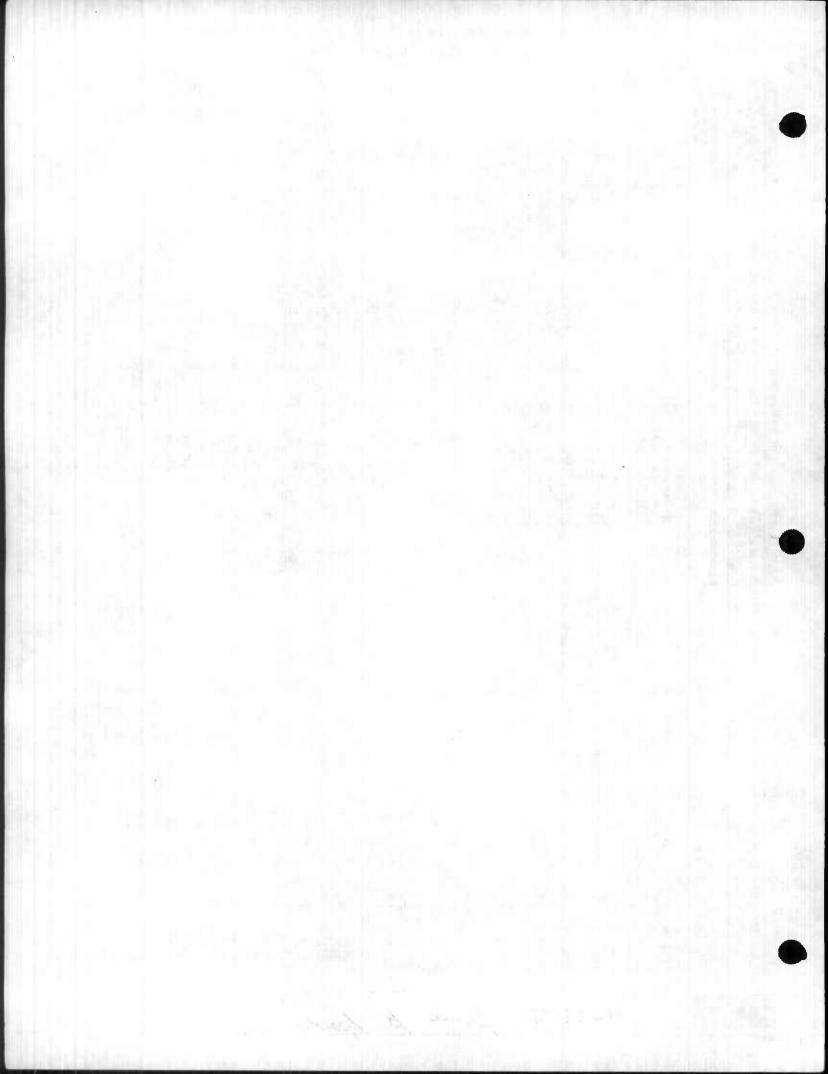
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625 Kent Avenue 32. Registrar's Signature

Cumberland, MD 21502 Suite 102

& sports

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental I Certificate of Death	Hygiene
Certificate of Death	Pag No

	Decedents None of the control of	41		Certificate			Reg. No.		9 Time -4 P "	
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of M	De. Street and Number	y		10f. Zip C			10g. Citizen of	What Counti	y?	
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11	. Meritel Stetus	12. Wes Decedent Armed Forces?		13. Wes Decede	nt of Hispanic C y Cuben, Mexic	Origin? (Specify Yes or an, Puerto Rican, etc.)	No- 14. Ra Ble	ce - America		
YF	1 Never Merried Married 3 Widowed 4 Divorced	14 Yes 2 1	II WW	1 ☐ Yes 2	☐ No Specif	ly:	Spaci	hite		
D D	15. Decedent's Ed	Yeer or Detes:	160	Decedent's Usuel	Occupation		16b. Kind of B		istry	
Die	(Specify only highest gra			(Give kind of work life. DO NOT use	done duning me retired)	ost of working				
1	Elementery/Secondary (0-12)	College (1-401)	Sr.	Vice Pr	esider	nt	Cumb. C	oncre	ete	
\$ 17	. Fether's Neme (First, Middle, Last)					her's Neme (First, Midd		me)		
P G	eorge K. Steir	.er			Mary	F (St	eele)			
	9e. Informent's Name/Reletionship (ary W. Steiner		109	N. Cha	Street and Num	ber or Rural Route Nur Ceet ; Cumb	mber, City or Towr erland.	MD21	502	
	a. Method of Disposition			Disposition (Name		Dete	20c. Location			
	X Buriel 2 □ Cremetion 3 □		cemeter	y, crematory or oth	er piece)	12/1	9			
2	4 Donetion 5 Other (Specify) S\$ Peter Paul Cemetery 2000 Cumberland									
og .	21. Signelore of Funeral Service Licansee Scarpel 11 eral Home P.A. Cumberland, Maryland 21502									
2	3e. Pert1. Enter the disease, or comp shock, or heart feilure. List only	plicetions thet caused	Ithe deeth. Do r					Approximete		
ian	shock, or heart feilure. List orly_	one ceuse on eech li	ne.						Interval Between Onset and Death	
ical In	nmediete Cause (Final isease or condition	Arter	iosclero	tic Hear	se			rears		
ier re	esulting in deeth)	0	Due to (or es e	00			Curo			
Examiner :		b						1		
S if	equentielly list conditions, any, leeding to Immediate ause. Enter Underlying		Due to (or es e	consequence of):						
T C	ause. Enter Underlying ause (Disease or injury set initieted events	C	Dai to facility							
iclan/Medic	esulting in deeth) Last	Due to (or es e consequence of):								
Physician/Med		d								
Pa Cas	art II. Other significant conditions o	entributing to death b	ut not resulting Ir	the underlying car	use given in Per	nt f. 23b. D	id tobacco uae c	ontribute to	the cause of death?	
Physic	Parkinson's Di	50250				1	□Yes 2NNo	3 Prob	ably 4 Unknown	
P 2	Tarkinson S Di	sease				(1 KH)	'	T		
Completed							erformed?	eve	re eutopsy findings lable prior to apletion of cause	
Comple							,		pletion of cause eath?	
8				4 31		11	Yes No	10	Yes 2□ No	
	5. Wes case referred to medical examiner?	Hospitel:			Other	ice of Death (Check on				
O 27	1 Yes 2 No 7. Manner of Death	1 ☐ Inpatie			c. Injury et Work?	-	esidence 6 Ot be how injury occu			
Certification:	Netural 5 Pending investigation	(Month, Da		njury M	Work? 1 ☐ Yes 2	□No				
HICE	3 Suicide 6 Could not be determined	200. Fleue Ul III]	28f. Locatio	n (Street and Num Town, State)	nber or Rural	Route Number,				
9	4 🗆 Homicide	building, et	с. (Бреспу)			CRY OF	TOWN, State)			
	9e. Certifier (Check only Check only	rsician: To the best	of my knowledge	, deeth occurred el	the time, date	end place, and due to t eeth occurred et the tim	he ceuse(s) end n	nenner as sta	ited.	
80 P	one)	and menner st	eted.							
ह ≥ 29	b. Signature end title of certifier)/			License numbe	or .	29d. Date sign	ied (Month, E	Pay, Year)	
0/						Dec 16, 2000				
6). Nema and eddress of person who	W			9157		Dec 1	6, 20	000	

State

Registrar

31. Dete filed (Month, Day, Year)
DEC 19 2000

32. Registrer's Signetare

Sports

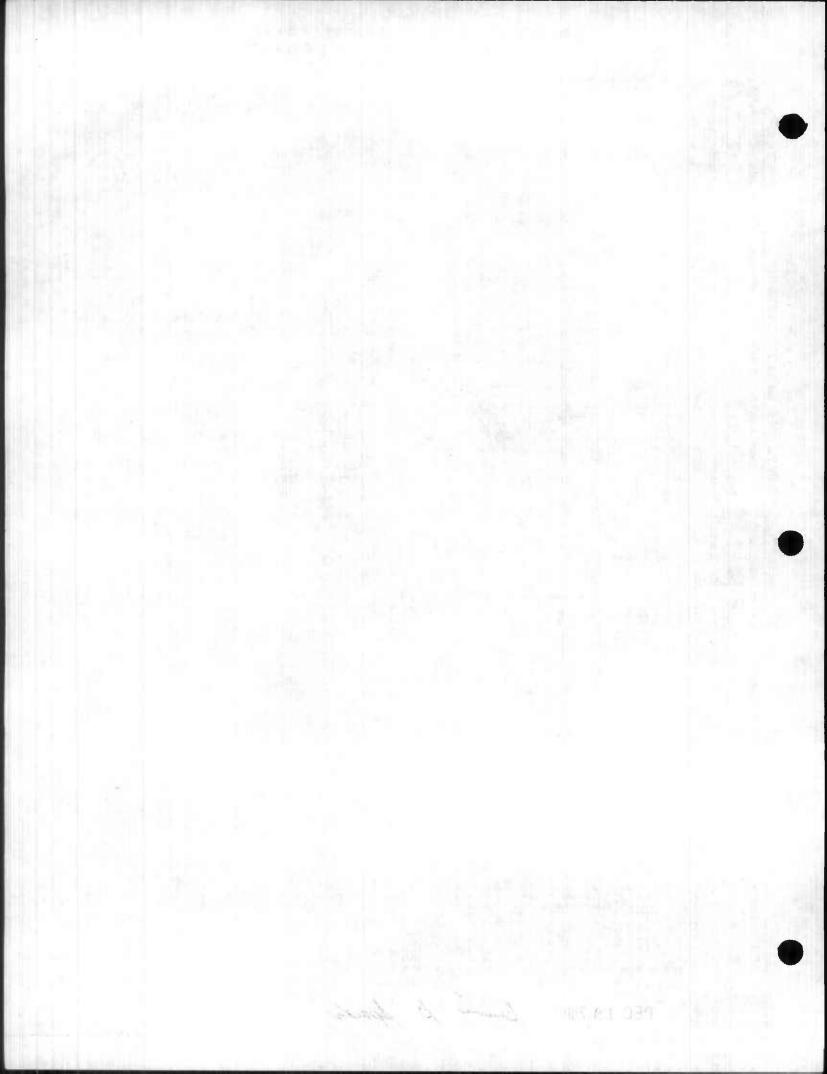
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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 2233

			Ce	rtificate	of I	Death		Re	g. No.			
	1. Decedent's Neme (First, Middle, Las)			13.		2.	Dete of Death			3. Time	of Death
Physician	James E	dward	Stewart				De	Dec 16, 2000 Yes			01:3	10am
/Medical Examiner	4e Facility Name (If not institution, give 14201 Harris La						wn, or Locati		4c. County	of Death	any	
Funeral Director		7. Age (In 8	yrs. last birthdey, 3 Yrs.	Months 1	1 Year Deys	If Under	24 Hrs. 8. Min. OC	Dete of Birth Month, Day, T 21,	Year) 1917	9. Birthpi Caun WV	lece (Stei try)	te or Foreign
2 >	Usuel Residence of Decedent	100	City Town as I	anation.						1 44	Od Include	Cin. 1 imin
or deeth with the Maryland fems 23e or 28e-f show fems 21 be notified at uneral Director	MD Allega		10c. City, Town or Location Cumberland								10d. Inside City Limits Y□ Yes 2□ No	
th with the 23e or 2 and 25 or 2	10a. Street and Number 14201 Harris La	ine		10f. Zip (2150	2		g. Citizen of W USA	het Coun	try?	
036 urs after arr., or its	11. Merital Status 1 Never Married	12. Was Decedent Ever Armed Forces? 1 2 Yes 2 NoW If Yes, Give Year or Dates:	M Van anneity Culture Marriage Directo F					Yes or No- an, etc.)	Black	America White, white, or	etc.	
5-0 72 hg 72 hg	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual	k done d	du <i>rina m</i> osi	t of working	1	6b. Kind of Bu	siness/Ind	lustry	201-4
d 21215-0036 filed within 72 hours at Hydiene. wither than "natural", or wit, in which the Hydiene.	Elementary/Secondery (0-12)	College (1-4or 5+)	Coning	DO NOT use	e retired	0		Te	xtile			
Ire, Maryland 212: 1 and 2 should be filed within If Heelth and Mentel Hygiene. Rem 27 is marked other than other traumatic event, the than To Be Comp	17. Fether's Name (First, Middle, Last) Charles Calvin	Stewart					r's Name (Fi phine		leiden Sumem LK	9)		
'e, Mary 1 and 2 sho Heelth end N em 27 is me Wher traums	19e. Informent's Neme/Reletionship (7) Dorothy Stewart								City or Town, and, MI			
Page nent: If ury or	20a Method of Disposition 12 Buriel 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	Db. Plece of Disp cemetery, cre	metory or oth	her plea			2/18	oc. Location		or Town, State	
Ballt permit. Departe Importa any lejk	21. Signatur of Funeral Service Licensee Scharped Address of Farificeral Home P.A. Cumberland, Maryland 21502											
Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ficalities that caused the ne cause on each line.	death. Do not er	nter the mode	e of dyin	ig, such as	cardiac or re	espiratory erre	st,	1		nate Between nd Death
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	e	Kenal	cual fulue					1 year			er
je je			Hup	. 1	non					í	10 Y	ears
hat the death certificate be executed ed by the ettending physicien end deteched for use as the bunal-trensit / Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last	c	to (or es a conse									
death certifice ettending of for use assician/Mc		d										
S, F.C. BO) es that the death ce gned by the ettend be deteched for us, by Physician	Pert II. Other significant conditions co	contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribut				se of death?
requires been sign should be								24a. Wes er perform	n autopsy ned?	CO	ere eutop ailable pri mpletion deeth?	sy findings for to of cause
The levele bage 2								1□ Ye	s 200	1 🗆	Yes 2	2□ No
clan: clan: entific entific sctor, sctor,	25. Was case referred to medical examiner?	11			0.1		of Deeth (C	heck only on	9)			
of VItal Physician: To this certificet eral director, pa n: To Be Co	27. Mapper of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Dey Yea	2 ER/Outpetie		Bc. Injur	4 LI NU	ursing Home		nce 6 Other		y)	
To the Hospital or Attending Physician: The Is within 24 hours after deeth. To the Funeral Director: After this certificate he completely filled in by the toneral director, page. Medical Certification: To Be Com	1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury -	At home, ferm, s	М	10	Yes 2		Location (Sti	reet and Numb	er or Rure	I Route N	lum <i>ber</i> ,
Certi	4 Homicide	building, etc. (S	pecify)					City or Town	, Stete)			
To the Hospital Within 24 hours To the Funeral completely filled Medical Co		sician: To the best of my ner: On the basis of examination inner stated.										se(s)
To the comp	29b. Signature end title of certifier	1		29c.	. Licens	e number		25	d. Date signed			r)
5		Den		D	0003	3280			Dec 1	8,20	00	
nus	30. Name end eddress of person who co Sunil K. Gupta	ompleted cause of deeth a. M.D. 625			ie C	Cumbe	rland	d MD 2	21502			
State Registrar	31. Date filed (Month, Dey, Year) DEC 1 9 2000	32. Registrer's S	Signeture	doors	2					5		

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Day December 14, 2000 **Physician** 9:30 Wilma Jean Serf /Medical 4e Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Shaded Grove Nursing Home Montgomery 9. Birthplace (State or Foreign Country) If Under 1 Year 7. Aga (In yrs. last birthday) **Funeral** Days Months 1□ M 21 F Yrs. Director 212-10-0140 Pennsylvania Oct. 5, 1910 Usuel Rasidenca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itema 23s or 28s-f show any Injury or other traumatic event, the Medical Examination in northed as 1 ☑ Yes 2 ☐ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19310 Clubhouse RD 20886 Funeral USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yes, Giva Yeer or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: 2 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Supervisor of Training Telephone Co. 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be 0 William Robert Dayton Victoria Jane (Troy) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 11929 Raven Rock Terrace, Gaithersburg, MD 20878 position (Nama of Dete 20c. Location - City or Town, Stata Janet S. King Friend 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 1X Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata Rose Hill Cemetery 4 ☐ Donation 5 ☐ Othar (Spacify) 12/18/00 Cumberland, Maryland 21. Signature of Furagal Sarvica Licansaa 22. Nama and Addrass of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each init. Approximete Intarvat Between Onset and Death Physician /Medical Immediata Causa (Final diseasa or condition rasulting in daath) Examiner Examiner Ischemic ears CZ Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): ears ZITCIY COVOUSUA VISEUS Physician/Medical to (or as a conseque e of 88 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autoosy 2P No 1 ☐ Yas 2 ☐ No 1 Yas 25. Was casa rafarred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending

Division of Vital Records. P.O. Box 68760.

the Meryland

Baltimore, Maryland 21215-0020

physician and the burial-transit been signed by the a should be deteched f page 2 funeral director, Medical

Certification: To

2 Accident

3 ☐ Suicida

29a. Cartifier

4 ☐ Homicida

(Check only one)

29b. Signetura end to of certifier

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely

5 Mh

State Registrar ortin

investigation

6 Could not be determined

29c. License number

28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29d. Data signed (Month, Day, Year)

ecemba

2000

28f. Location (Street and Number or Rurat Routa Number, City or Town, State)

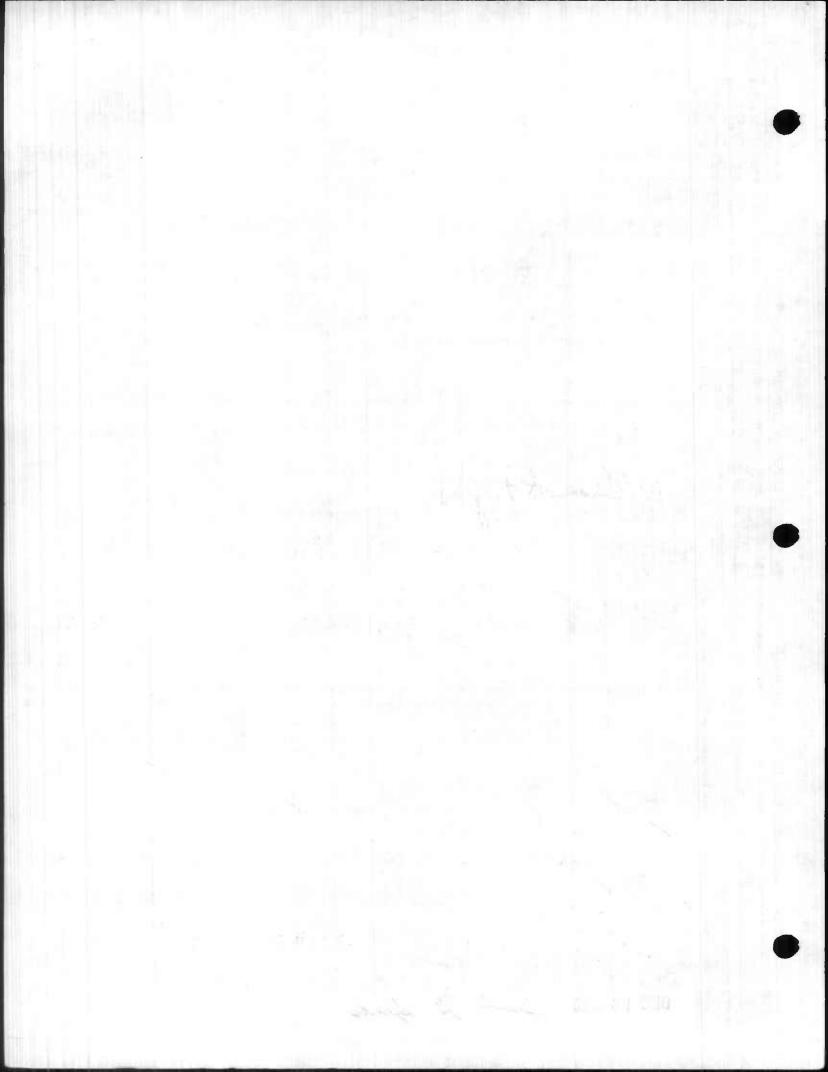
30. Nama and addrass of parson who complated causa of death (m 23m) (Type, Print)

Dolinsky 911 MO C 1 9 ZOOO 32. Registrar's Signatura

Russell

1 ☐ Yas 2 ☐ No

Gaithersburg



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Shaffer Helen Dec 21, 2000 06:06am 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death | Cresapco... | H Under 1 Yaer | If Under 24 Hrs. | 8. Deta of Birth (Month, Day, Year) | Under 1 15, 19 14501 Amcelle Street Allegany 5. Sociel Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) PA 10M 20F 74 Yrs. 215-20-7191 Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Y Yes 2 No MD Allegany Cresaptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14501 Amcelle Street 21502 USA 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas X ☐ No if Yas, Giva Yeer or Detes: Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian 11. Maritel Stefus Black, White, etc. 1 Nevar Married X Merried 1 Yas 2 No Specify Specify white 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT usa retired) Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Jacob H. Miller Cora (Bittinger) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 14501 Amcelle Street; Cresaptown, MD21502 Robert J. Shaffer thu shand or disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 12/23 Burial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Garrett County Memoria 2000 Cakland, MD \$22 Name and Address of Facility \$Carpelli Funeral Home P.A. Cumberland, Maryland ns that causad the death. Do not aniar the mode of dying, such es cerdiac or respiratory arrest, 23a. Part1. Entar the disease, or complications shock, or heart failure. List only one cause Approximete Intarval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or as a consequence of) Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disaasa or injury that initiated avents resulting in deeth) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Other: 4 ☐ Nursing Homa 5 € Residence 6 ☐ Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Roula Number, City or Town, Stata) 6 Could not be datarmined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

been signed by the attending physician and should be deteched for use as the burial-transit The law requires that the death certificate be executed pital or Attending Physician: The law burs after death. eral Director: After this certificate has filled in by the funeral director, page 2: To the Hospital within 24 hours a To the Funeral Completely filled

Physician

/Medical

Examiner

Funeral

Director

than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

72 hours after

filed within 7 Hyglene.

2 should be fi and Mental 9 is marked

permit. Pages 1 and 2 st Department of Health and Important: If Nem 27 is n

Physician

/Medical Examiner

Physician/Medical Examiner

by

Completed

Be

2

Certification:

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Division of Vital Records, P.O. Box 68760,

Medical 3 6

29b. Signature and title of certified

4 THomicida

29a. Cartifiar

Wha

TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D17526

29d. Date signed (Month, Day, Year) Dec 21, 2000

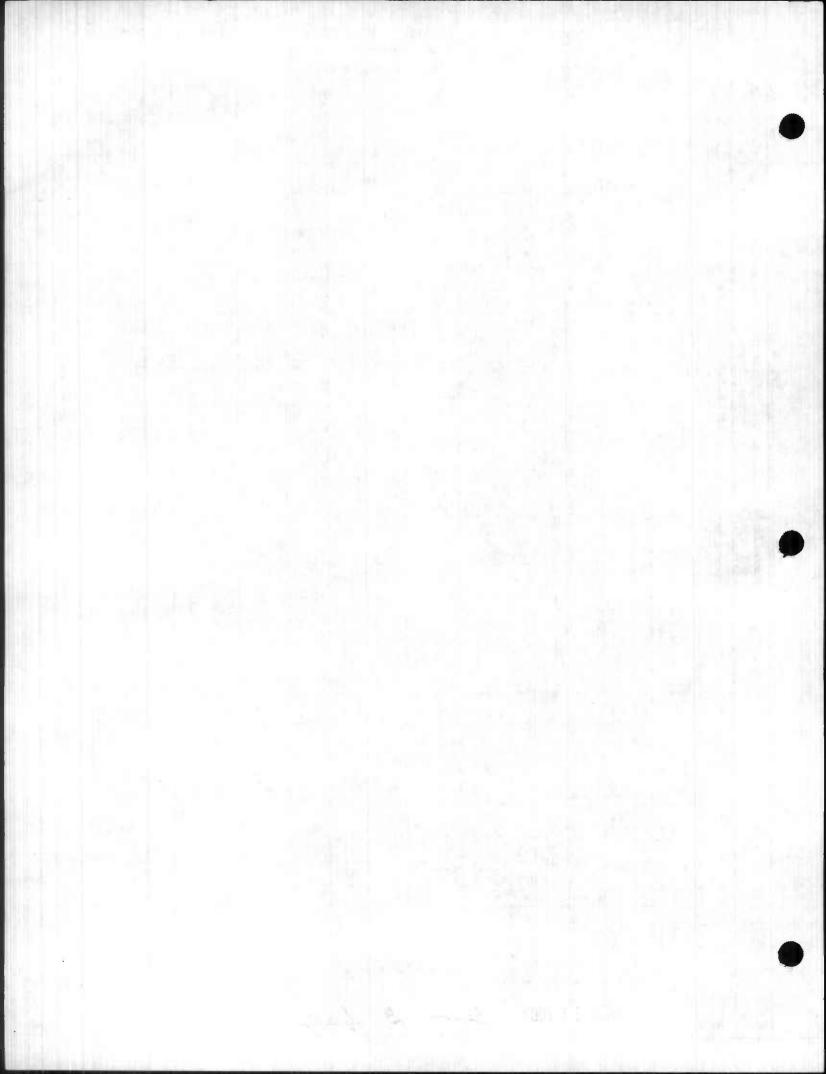
30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Frint)

John N Mehanna M.D. 902 Seton Drive Cumberland MD 21502

State Registra

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year) 21 2000 32. Registrar's Signatura



State of Maryland / Department of Health and Mental	Hygiene	^		0	,
Certificate of Death	Reg. No.	U	L	2	1

				Ce	rtificate c	of Death		eg. No.	6650
Physi /Med		Decedent's Name (First, Middle, Last JOHN RUSSELL S) TIMMETZ				2. Date of Dea Month December	Day Ye	
Exam		4a Facility Neme (If not institution, give					or Location of Death	4c. County of D	
	_	Sacred HEART HOSE 5. Social Security Number 6. Se		(In yrs. last birthday	If Under 1 Ye	Cumber		Allega	ad.
Funera Directo		220-80-7457	M 2□ F	39 Yrs.	Months Da	ys Hours M	s. B. Date of Birth (Month, Dey DECEMBER		Birthplace (State or Foreign Country) MARYLAND
andre		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation	15 P N			10d. Inside City Limits
the Maryle 28s-f sho	Funeral Director	MARYLAND ALLEGA	NY	CUI	MBERLAND			log. Citizen of What	1 ☐ Yes XX No
with the or	百	10e. Street and Number	/ENTYE		10f. Zip Cod			U.S.A.	Country
n 23	era	11907 BAYBERRY AV	12. Was Decedent B	Ever in U.S. 13.		502 of Hispanic Orlgin?	(Specify Yes or No-		merican Indian,
5-0036 72 hours efter deeth with the Maryland naturel', or herna 23a or 28a-f ahow deel Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 27 N If Yes, Give Year or Dates:	lo	If Yes, specify C		(Specify Yes or No- erto Rican, etc.)	Specify: [/hite, etc. VHITE
5-0036 72 hours of natural; or	Be Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Giv	edent's Usual Oc e kind of work do	ne during most of v	vorking	16b. Kind of Busine	ess/Industry
2121 d within giene. or then	mp	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use re		11.75	UN KNOWN	
N Pas	ပိ	12 17. Fether's Neme (First, Middle, Last)		GOOD	WILL IND		lame (First, Middle,		
Maryland 2 hd 2 should be filed tith and Mental Hygi P7 is marked other traumatic event.	OB	JOHN VINCENT STIM	METZ			ESTHE	R MAXINE 2	ZEMBOWER	
and N		19a. Informant's Name/Relationship (T)	ype, Print)				Rural Route Number		
S 5=25		ESTHER STIMMETZ	МОТН				T		LAND 21502
0 87 = 8		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ f 4 □ Donation 5 □ Other (Specify)			emetory or other	plece)	3, 2000 C	20c. Location - City UMBERLAND	
_ 1021		23a. Part1. Enter the disease, or compshock, or heart failure. List only of	al	2	22. Name and Ad IERRITT—A 104 DECA Inter the mode of	ADAMC TIM	ERAL HOME T CUMBERL liac or respiratory ari	P.A. AND MARYL	AND Approximate Interval Between Onset and Death
Physician /Medica Examine	ı	Immediate Cause (Final disease or condition resulting in deeth)	· ASA	PHYXIA	aguence of				1
d d d d d d d d d d d d d d d d d d d	miner	b. CHOKING ON A KOOD BOLUS Due to (or as a consequence of): Due to (or as a consequence of):							
68760, tificate be asscuted g physician and as the bunal-transit	edical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c						1
	1000	resulting in death) Last	d	Due to (or as e conse	equence or):				
Box deeth cer e attendin	Iclan	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the	underlying cause	given In Part t.	23b. Dtd to	obacco use contrit	outs to the cause of death
s that the de igned by the s	/ Phys	SEIZURE DISO					101	/es 200 3[Probably 4 Unknow
ord requir	Completed by Physician/N						24e. Was a		4b. Were eutopsy findings evailable prior to completion of cause of death?
I Rec	отр						110	es 2□No	1 ¥Yes 2□ No
yalclan: The Is certificate he director, page	BeC	25. Was case referred to medical				26. Plece of I	Death (Check only o		
of VIta Physician: rihis certific and director,	10	examiner? 1√2 Yes 2 No	Hospital: 1 🗆 tnpatie	nt 2 ER/Outpati	ent 3 DOA	Other: 4 Nursin	g Home 5 ☐ Resid		
nding Phoeth.	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Dey /2/20/	Year) Injury	of 28c. I	njury at Work? 1 □ Yes 2 🗷 No	28d. Describe h	ow injury occurred OON AB	SUBJECT OLUS OF FOOD
DIVISIO Hospital or Atlandi 24 hours after deeth. Funeral Director: A ately filled in by the fi	edical Certification:	3 Suicide 6 Could not be determined		ury - At home, farm, s		ice			T Rural Route Number,
Hospital 24 hours Funeral itely filled	2	29a. Certifier 1 Certifying Phy	sician: To the best of	f my knowledge, dea	th occurred et th	e tima, date end pla	ace, and due to the o	cause(s) end manne	er as stated.
n 24 h	edic	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination and/or i	nvestigetion, in n	ny opinion, death o	ccurred at the time, o	sate and placa, and	due to the cause(s)

29d. Date signed (Month, Dey, Year) 29c. License number O.C.M.E. December 21,2000

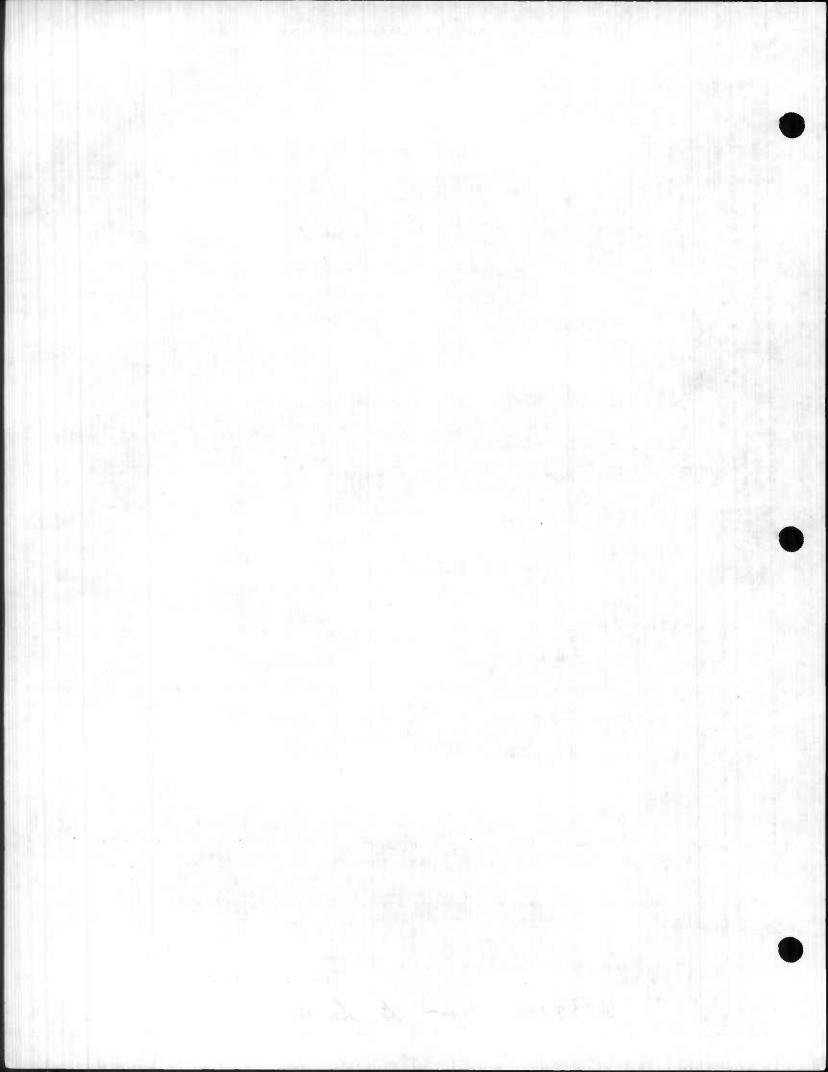
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MANY G. AIPPLA A.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)
DEC 2 2 2000 32. Registrar's Signeture

With To t



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Physician 20, 2000 Florence Sorrells G. Dec 11:40am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital & Medical Ctr Cumberland Allegany If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Funeral 10 M 20 F 25, 213-24-6714 72 1928 WV Director Apr Usual Rasidance of Decedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Insida City Limits eo otner than "natural", or flams 23s or 28s-f show event, the Medical Examiner must be notified at J∏Yas 2□No Directo Mineral Ridgeley 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? P.O. Box 102 26753 USA Funeral 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yas ሺ ☐ No It Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amaricen Indian, 11. Marital Status Black, Whita, atc 1 Navar Married 2 Married 1 Yas 2 No Specify. Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) filed within Hygiens. Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) permit. Pages 1 and 2 should be Department of Health and Mental important: if flam 27 is marked or say injury or other traumatic eve Leonard Squires Mable (none) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Intormant's Name/Ralationship (Type, Print) Brenda George P.O. Box 102; Ridgeley, WV26753 Baltimore, 20a. Me Boo of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 12/22 1 ☐ Burial X ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Specify) Scarpelli Funeral Home 2000 Cresaptown, MD Scarpelli Funeral Home P.A. 21. Signatura of Funaral Sarvice Licenses Cumberland, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting In deeth) /Medical Acute Respiratory Failure 24 hours Examiner Dua to (or as a consequence ot): 5 years Examiner Chronic Obstructive Lung Disease The lew requires that the death certificate be executed attending physician and for use as the bunal-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseasa or injury that initiated evants Dua to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquanca ot) rasulting in daath) Last ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. signed by t 1 □ Yee 2 □ No 3 □ Probably 4 □ Unknown Cancer of the Cervix with Local Metastasis þ 24b. Were eutopsy findings available prior to complation of causa of death? been signature of the second o 24a. Was an autopsy performad? Completed certificate hes l paga 1 Yes 2 No Physician: Be 25. Wes casa retarred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Impatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Lo 1 Yas 2 No After this 28e. Date of Injury (Month, Day Year) funeral 28b. Tima ot 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Mannar of Death Certification: Hospital or Attending 5 Pending invastigation Natural death. 1 Yas 2 No offer death Director: / d in by the f 2 Accidant 6 ☐ Could not be 28t. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, tarm, straat, tactory, office building, atc. (Specify) 4 D Homicida To the Hospital within 24 hours or To the Funeral Completely filled 1 Cortifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the causa(s) end manner es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar edicai (Check only one) 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signatura and title ot certities M. O Dec 22, 2000 D23334

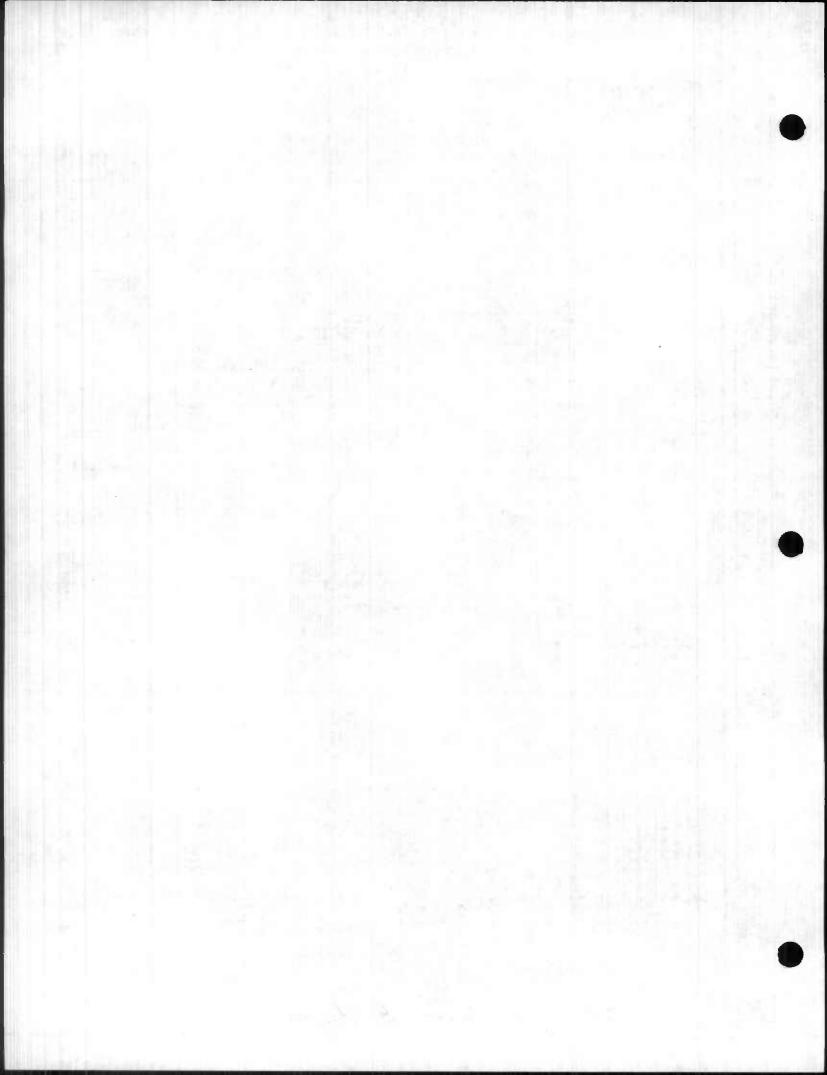
M

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

Shah M.D. 625 Kent Avenue Cumberland MD 21502

State Registra

31. Data filed (Month, Day, Year) 32. Registrer's Signatura DEC 22 Geneva 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Dete of Death

3. Time of Death

1. Decedent's Neme (First, Middle, Last)

State Registrar

WI

29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Year)

Coustians

Robustiano J. Barrera.

DEC 2 6 2000

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32. Registrer's Signeture

30. Name end eddress of person who completed cause of deeth (Itam 23a) (Type, Print)

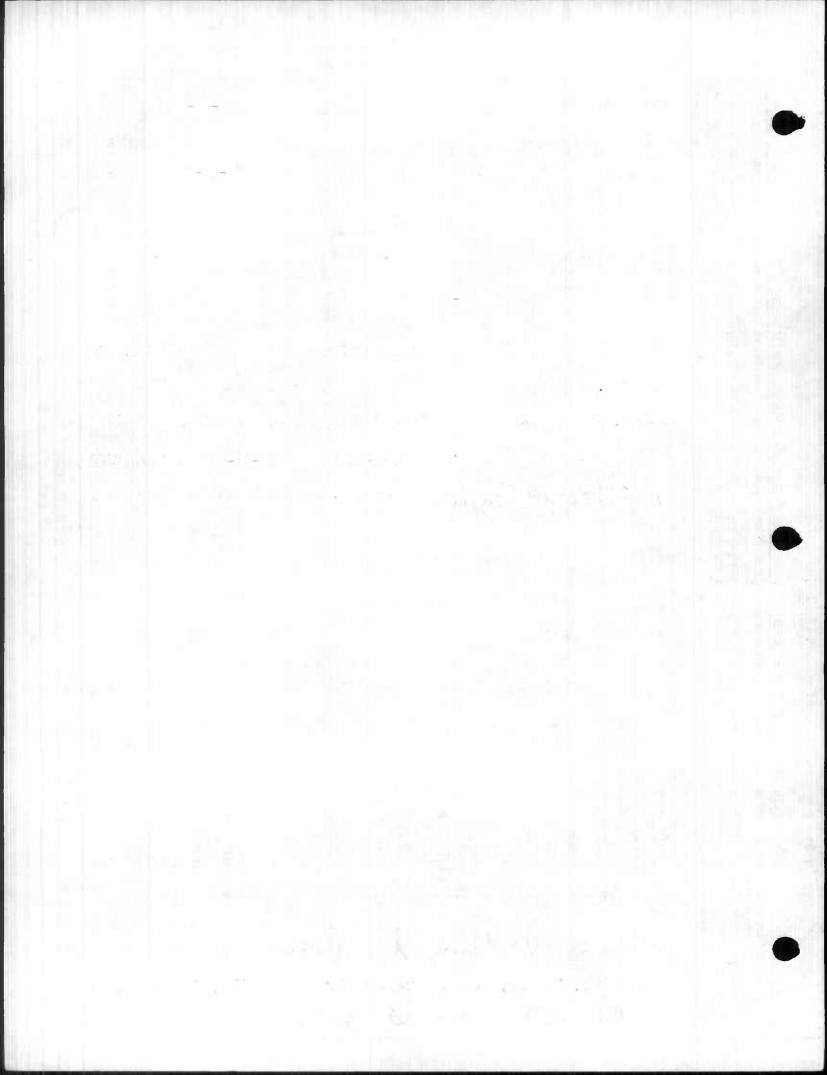
29c. License number

D-14865

Memorial Hospital Medical Building, Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

DEC. 26,2000

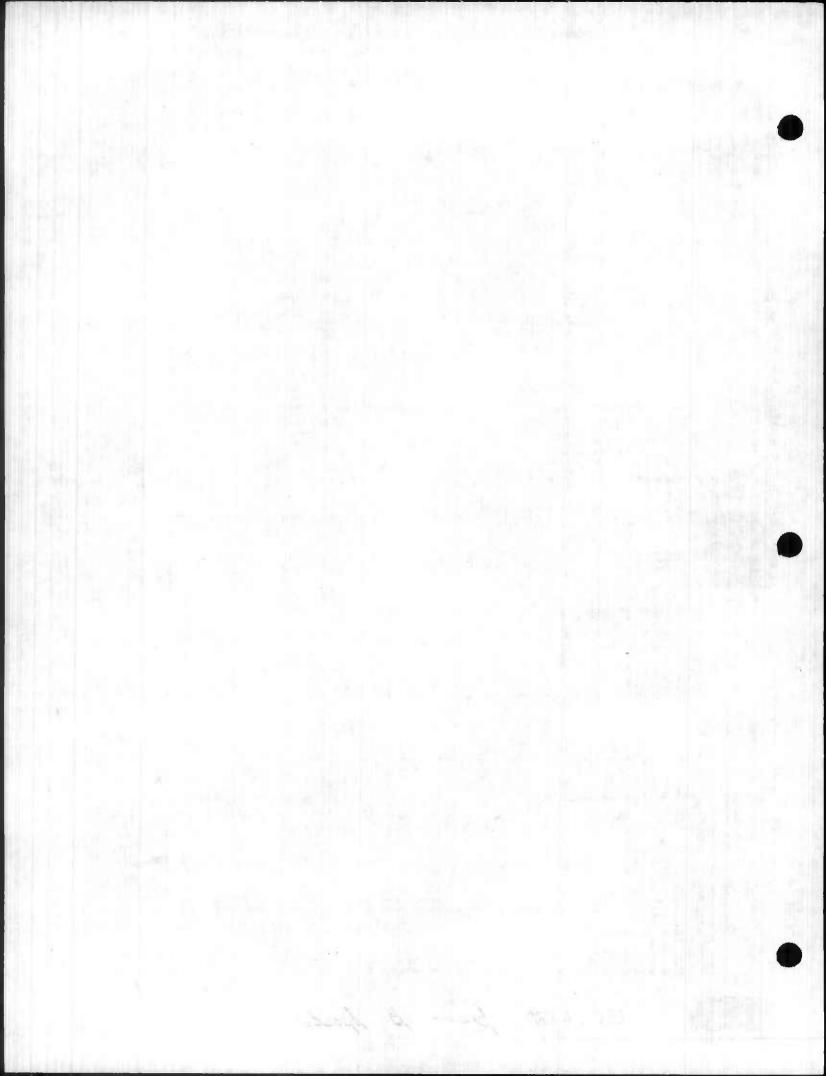


Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Year **Physician** Shambaugh Donald Ray 20, 2000 14:45 December /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital & Medical Center Cumberland Allegany Hours Min. 8. Date of Birth (Month, Dey, Year)

Jun 3, 1935 If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country)
 WV 10 M 20 F **Funeral** Months Deys 65 Director 220-32-4130 Usual Residence of Decedent with the Maryland Hygiene. hydrothan "natural", or frams 23a or 28a-f show ent, the Medical Examiner must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Cumberland MD Allegany 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 21502 25 Oak Street death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No If Yes, Give Yeer or Date<u>1</u>: 9 5 6 − 5 8 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elemantery/Secondery (0-12) College (1-4or 5+) Service Technician Potomac Metals 12 7 is marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if Itam 27 is marked othe any Injury or other traumatic event, bage. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) (Alderton) Olivia Ovey E. Shambaugh 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Pnint) 25 Oak Street; Cumberland MD 21502 Lois A. Shambaugh Wal Mercod of Disposition 20b. Place of Disposition (Neme of cemetery, crametory or other piece) Dete 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Othar (Specify) 12/23 Hillcrest Memorial Par2000 Cumberland, MD 21. Signature of Funeral Service Licensee Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, or compiled one that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** Immediate Cause (Final diseasa or condition resulting in deeth) /Medical Lymphoma Examiner 1 year Dua to (or as a consequance of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury Due to (or es e consequence of): P.O. Box 68760 Physician/Medicai thet initieted events resulting in death) Last Due to (or es e consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Division of Vital Records, by 24b. Were eutopsy findings evailable prior to 24a. Wes en eutopsy performed? Completed completion of cause of daath? certificate has b lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Hospital or Attending Pi
 24 hours after death.
 Funeral Director: After ti After t Certification: 28c. Injury at Work? 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident the 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours a To the Funeral E completely filled 12 Certifying Physicish: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examinary On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 7 2000 December D0023371 3 4 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) mel 625 Kent Avenue Suite 102 Cumberland, MD Dr. Oamar U. Zaman 31. Dete filed (Month, Dev. Year) 32. Registrer's Signeture State DEC 2 6 2000 Registrar oaks

ORIGINAL



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year Thomas Sluss DECEMBER 26, 2000 1:23 A.M. 4a Facility Nama (tf not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Sacred Heart Hospital Cumberland If Under 24 Hrs. 8. Data of Birth Hours Min. Aug 15, Year 1929 If Under 1 Yaar Birthpleca (Steta or Foreign County) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Days XI M 2 F Months 218-24-8113 71 Usual Rasidence of Decedant 10d. Inside City Limits 10a, Stata 10c. City, Town or Location 10b. County 17 Yes 2 No Allegany Frostburg 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? B48 Grandview Drive 21532 USA Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas Q☐ No Specify: Specify: white 3 Widowad 4 Divorced 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working tife. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) State of Maryland Contractual Employee 18. Mothar's Nama (First, Middle, Maiden Sumeme) 17. Fether's Nama (First, Middle, Last) (Williams) Louis Sluss Margaret 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 48 Grandview Drive; Frostburg MD 21532 19a. Informent's Name/Relationship (Type, Print) Camille Sluss Wife 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 12/28 Buriel 2 Cremetion 3 Ramoval from Steta 4 Donation 5 Othar (Specify) Frostburg Memorial Par2000 Frostburg, MD 21. Signature of Funaral Service Licenses Scarpedition Fullieral Home, P.A. Cumberland, MD 21502 23a. Part1. Entar tha diseasa, or complications that caused the deeth. Do not antar tha mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on sech line. Intervel Between Onset and Death Immediata Ceusa (Final disaasa or condition resulting in death) Cerebrovascular Accident twodays Dua to (or as a consaquance of): Not known Cancer Due to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yee 2 No 3 Probably 4 Unknown Embolism Pulmonary 24b. Wara autopsy tindings eveilabla prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

ed by the attending physician and detached for use as the burial-transit

been signed by t should be detact

page

funeral director,

After this certificate has

To the Mospital or Attending Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funera

s after deameral Director: After

Physician:

The law requires that the death certificate be executed

Box 68760,

Division of Vitai Records, P.O.

Examiner

Physician/Medical

by

Completed

Be

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Certification:

edical

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or hame 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after death w Department of Health and Mental Hygiene, in T2 hours after death w Important: If then 27 is merked other than "netural", or there 23s, wany injury or other traumatic event, the Medical Execution 20s.

Baltimore, Maryland 21215-0036

Directo

Funeral

by

Completed

Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaase or injury that initiated evants rasulting In death) Last 25. Wes case refarred to medical axaminar? 1 Yas 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

1 Yas 2 No 1 Yas 2 No 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 28d. Dascribe how injury occurred

28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Mennar of Death 28c. tnjury et Work? 5 Pending investigation 1 Neturel 1 □ Yas 2 □ No 2 ☐ Accident 6 ☐ Could not be datarmined 3 ☐ Suicida Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 ☐ Homicida Certifying Physician: To the best of my knowledga, daath occurred at tha tima, dete and place, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end mennar stated. 29a. Certifier

(Check only one) 29b. Signature end title of certifier

29c. Licanse number 00055325 29d. Date signed (Month, Day, Year)

2000

DECEMBER 26

workoute 30. Name end eddress of person who complated causa of death (Item 23a) (Type, Print)

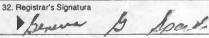
Frostburg, 40 21532 M.D 48 Tarn Terrace Wonsock Suite 204 Shim 31. Dete filed (Month, Dey, Year)

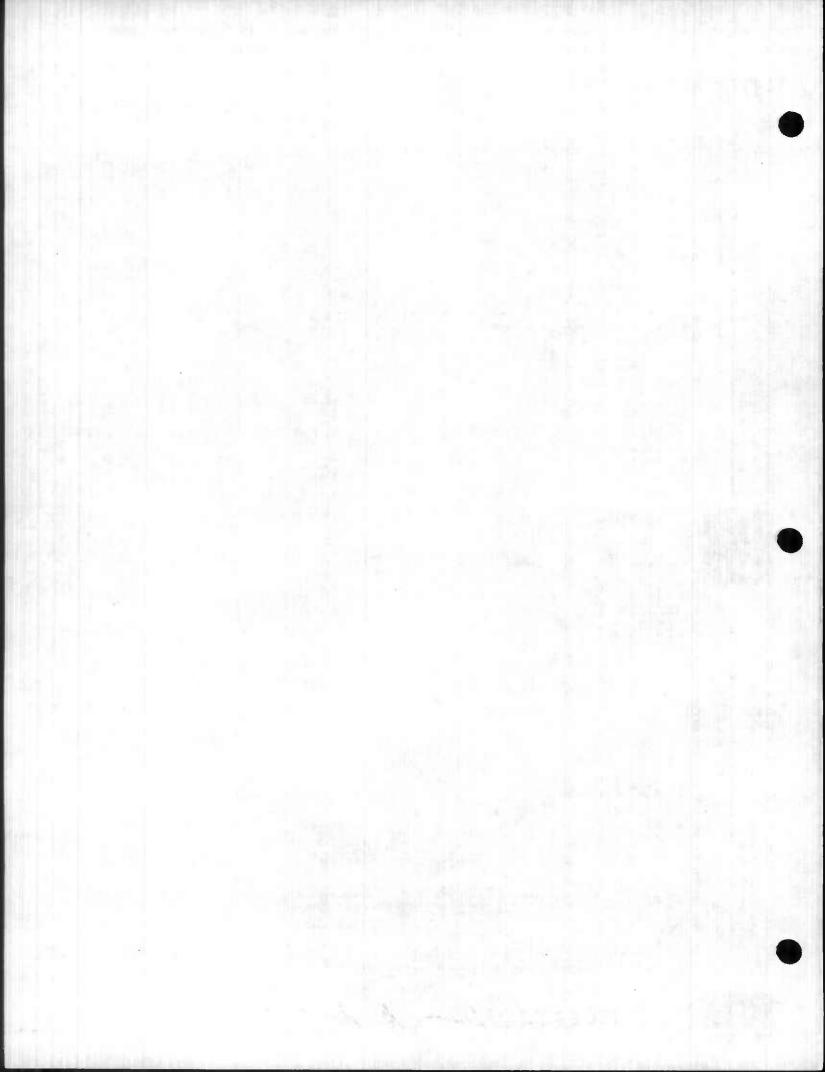
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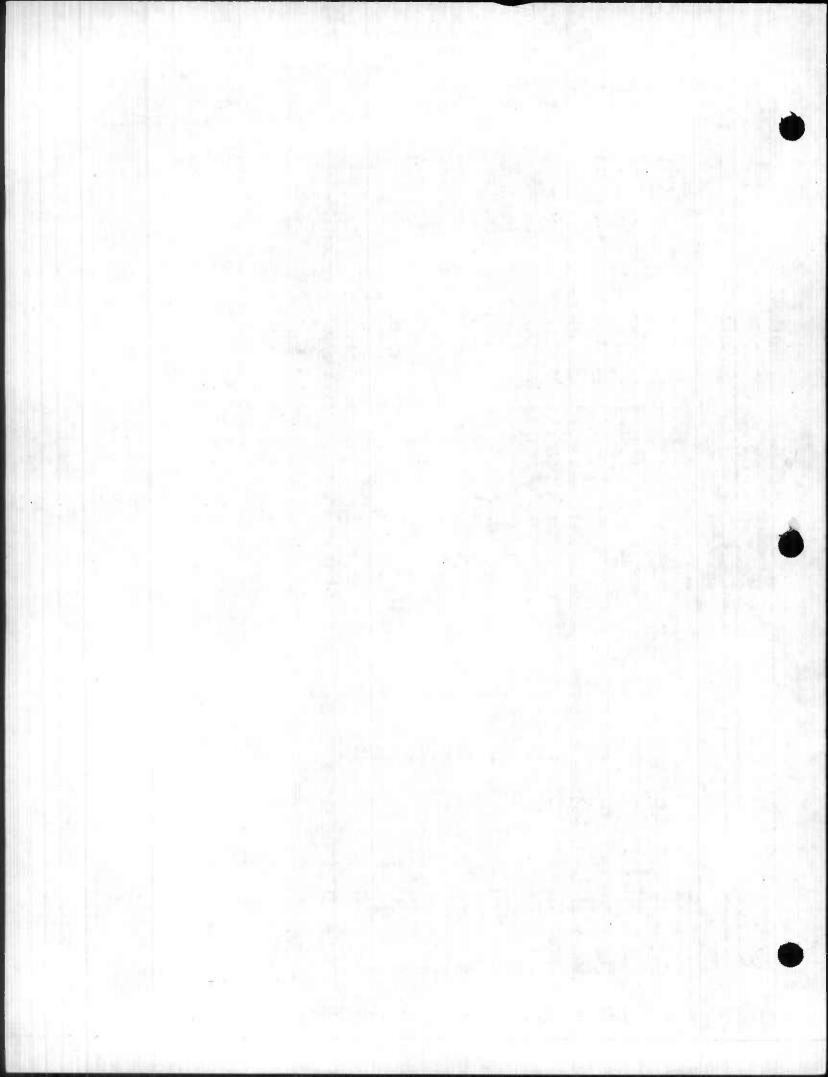


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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28a-f show notified at	Usual Rasidance of Decedant 10a. Stata 10b. County MARYLAND MONTO	OMERY	10c. City, Town	or Location	VILL	AGE			10d.	Inside City Limit
ma 23a or 28a-f show crust be notified at neral Director	10e. Street and Number 10413 MERCADO	WAY			ip Code 0886			10g. Citizen of V		
or the	11. Marital Status 1 Naver Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1		13. Was Deco		lispanic Origin? (Sen, Maxican, Puerl	pecify Yas or No o Rican, atc.)	14. Rac Blac Specify	e - Amarican ck, White, etc	
			5+)	Decedent's Us Giva kind of w lifa: DO NOT	ork dona	during most of wo	rking	16b. Kind of Bu	usinass/Indus	stry
Mental Hyg arked othe atic event, To Be C	17. Fethar's Nema (First, Middle, La CLAUDE ALLAN N						ma (First, Middla, WIRSCH	Maidan Sumam	ia)	100
Haalth end tem 27 is m other traum	19a. Intormant's Name/Ralationship JONATHAN H. THO 20a. Mathod of Disposition 1 □ Burial 2 ὧ Cramation 3	RN (SOI	20b. Place of [20 MAS Disposition (Na cramatory or	TENB			SBURG, I	MD . 20 City or Town	886 , Stata
Department of Important: If I any injury or other.	4 Donation 5 Other (Spe 21. Signatura of Funaral Sarvice Lie 23a. Part 1. Enter the disease of control of the shock, or heart tailure. List or	Sensee Www.	/	22. Name 2 DEV #10	od Addre	ss of Facility UNERAL HI T DEER PA	OME ARK DR	GAITHER:		VIRGINI
usa as the burlal-transit usa as the burlal-transit www.xwedical Examiner	Immediata Causa (Final diseasa or condition rasulting in daath) Sequantially list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Disease or Injury thei Initieted events rasulting in death) Last	c ATRIA	DNIA Dua to (or as a co IC OBSTRU Dua to (or as a co L FIBRILI Dua to (or as a co	ICTIVE prisequance of LATION	PULM):	ONARY DI	SEASE		D	AYS EARS EARS
y the attenched for a	Part II. Other significant conditions	contributing to death b	out not resulting in	the undarlying	cause giv	ven in Part I.		tobacco use co		
or death. ector: After this certificate has been signed by the attenty that funeral director, page 2 should be deteched for illication: To Be Completed by Physicial							24a. Was	an autopsy ormed?	24b. Were	autopsy tinding
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this central direct	axaminar? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 ER/Out	patient 3 🗆 🛭	OH OH	201.	Homa 5□Rasi		er (Specify)	
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by tha funeral director, page 2 Medical Certification: To Be Comp	27. Menner ot Deeth 1 \(\overline{\text{Z}} \) Natural 2 \(\overline{\text{Accident}} \) 3 \(\overline{\text{Sulcida}} \) 4 \(\overline{\text{Homicida}} \) 6 \(\overline{\text{Could mondatarmin}} \) data min	t be 28a. Place of Ini	iry Year) 28b. Ti Inj jury - At home, fam c. (Specify)	ury M		ry at rk? ∣Yas 2 □ No		how injury occur Straat and Numb wn, Stata)		Routa Number,
• Funeral letely filled		Physician: To the best aminer: On the basis o and menner st	t axamination and							
To the comp	29b. Signature and title of certifier	3 all ms		2		ise number		29d. Data signe		UUU
State	30. Name and addrass of person wing JOSEPH A. BAI 31. Data filed (Month, Day, Year)	L - 11501		AVENUE,	SUI		WHEATON	, MARYL	AND 20	902



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year Physician 12:05 am Michael Tewalt December 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Johns Hopkins Bayrow Medical Center Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Mooth, Day, Year) July 12, 1957 5. Social Security Number 7. Age (In yrs. lest birthdey) 6. Sex 9. Birthplaca (Stete or Foreign **Funeral** Months Deys Country) Virginia 10 M 20 F Hours 231-90-3890 43 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits T is marked other than "natural", or itema 23s or 28s-f above traumatic event, the Mexical Exercises mant to motified at X□ Yes 2 □ No Director Warren Front Royal 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 846 West 11th Street 22630 USA Funeral 72 hours after deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Biack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry se filed within 7. Ital Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) Electrician Publishing Company 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Nem 27 is marked oth-any Injury or other traumatic event 17. Father's Neme (First, Middle, Last) James R. Tewalt, Sr. Georgia A. Moore 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informenf's Neme/Relationship (Type, Print) 846 West 11th Street Front Royal, VA 22630 Dietra A. Tewalt - Wife 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 🛣 Cremation 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) Panorama Memorial Gdns 12/18/00 Water Lick, VA 22. Name and Address of Facility
Maddox Funeral Home, Inc. 21. Signature of Funerel Service Licensee P.O. Box 442 Front Royal, Virginia 22630 de 000 No 23a. Purt Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, social, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finet diseese or condition resulting in death) /Medical Adult Respiratory Distress Syndrome days Examiner Physician/Medical Examiner Pulmonary interstitial infil trates 6 weeks attending physician and if for use as the buriel-transit The lew requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): isigned by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown b page 2 should b 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy Completed 1 Yes 2 No ils certificate I 2 No Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitet: 1 Inpatient 2 ER/Outpatient 3 DOA 1□ Yes 2☑ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1 Matural 5 Pending investigation efter deeth.

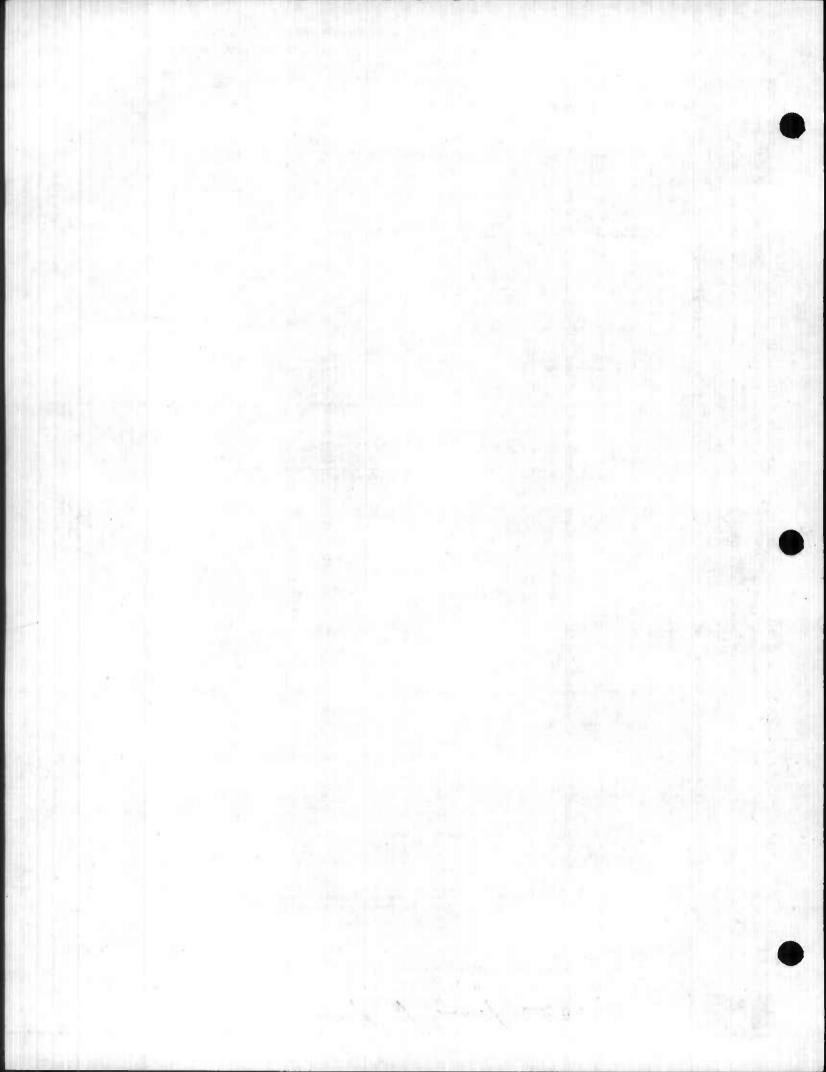
I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end manner stated. 29a Certifier edical (Check only one) 29b. Signeture and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) Muleua Gotleman, MD Resident Physician December 14,2000 21015 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca Gottesman MD, Johns Hopkins Bayvian Medical Center, 4940 Eastern Avenue, Baltinger Moryland 32. Registrar's Signeture 31. Date filed (Month, Dey, Year)

State Registrar

DEC 19

2000

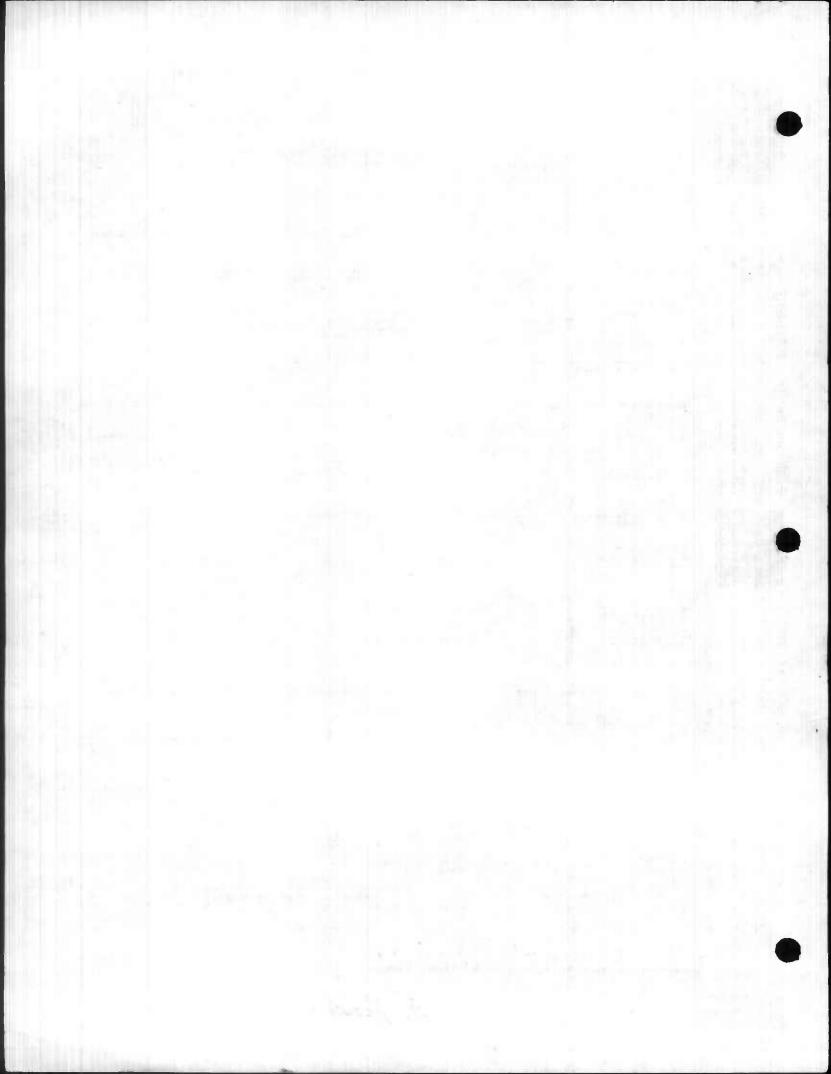


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

sician	Cei	rtificate of Death	Reg. N	10.UU 4	6640
sician	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
edical	Barbara Terry			19, 2000	10:30PM
miner	a Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	lc. County of Death	
	Layhill Center Genesis	Silver S		Montgomer	у
ral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Yea	9. Birth	place (State or Foreign
or	3/8-38-8443 /9 115		Apr. 23,	1921 New	York
	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ncation],	10d. Inside City Limits
5					1 ☐ Yes 2 ☑ No
Director	Maryland Montgomery Rockville		140-4		•••
		10f. Zip Code		Citizen of What Coul	
Pra	261 Congressional Lane, #713	20852		ited Stat	
Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White,	
by a	1 Never Married 2 Married 1 Yes, 2 No 1 Yes, Give 3 Widowed 4 Divorced Year or Detes:	1 Yes 2 No Specify:		Specify: Tills	ite
		dent's Usual Occupation	16h	Kind of Business/In	
Completed	(Specify only highest grade completed) (Give	kind of work done during most of wo DO NOT use retired)	orking 100.	KIRO OI DUSINGSS/III	dostry
Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)	retary		niversity	
ŭ ŀ	7. Fether's Name (First, Middle, Last)		me (First, Middle, Maid		
9 Be	Charles Terry	Gladys	I I I a lan as an		
٩		ng Address (Street and Number or R			Code) 2000
		Fairmont Street			
1	Oa. Method of Disposition 20b. Place of Dispo	sition (Name of		Location - City or To	
	1 Li Bunai 2 Al Cremetion 3 Li Removel Irom State	matory or other place)	Dec 21		
-		Crematorium, Inc.		ethesda, l	
	British Purietal Services Licenses	ethesda-Chevy Cha	ase. Inc.	7557 Wisc	onsin Avenu
	M00803 B	ethesda-Chevy Cha ethesda, Maryland	20814-35	01	
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardia	c or respiratory errest,		Approximate Intervel Between Onset end Death
	\wedge				Onset end Death
	Immediate Cause (Final disease or condition	orlia		!	2 usook
	resulting in death) a Due to (or es a conseq	quence of):	742780	i i	. 0
la la	5 taphulo	ccorcal s	ensis	i	10 clay
Examiner	Sequentially list conditions, fany leading to immediate	quence of):			-
	Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury c.				
edical	that initiated events Due to (or es a consequent of the consequence o	quence of):		i i	
5	d				
<u> </u>				1	
Physician/	art II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23b. Did tobac	co use contribute t	o the cause of death
~	100100000000000000000000000000000000000	11001	1 Yes	2 No 3 Pro	
	A COURT OF A CO				bably 42 Unknow
P	parigness ca	nec	040 Was an away	24b W	7
þ	ranginger Ca	<u>u</u>	24a. Wes an eu performed	91	fere eutopsy findings
by	pargrigue Ca	<u> </u>		ev co	ere eutopsy findings
P	pargage ca		performed	ev cc of	ere eutopsy findings vallable prior to empletion of cause
Completed by	25. Was case referred to medical avaninar?	26. Place of De	performed	ev cc of	Vere eutopsy findings vailable prior to perpletion of cause death?
þ	25. Was case referred to medical examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatien	Other	performed*	2 No 1	fere eutopsy findings railable prior to empletion of cause death?
To Be Completed by	examiner? 1 Yes 2R No Hospitel: 1 Inpatient 2 ER/Outpatien 77. Manner of Death 28a. Dete of Injury 28b. Time of	nt 3 DOA Other: 4 D Nursing	performed	en oc of of 2 No 1	fere eutopsy findings railable prior to empletion of cause death?
To Be Completed by	examiner? 1 Yes 2E/No	nt 3 DOA Other: 4 D Nursing	performed 1 Yes eath (Check only one) Home 5 Residence	en oc of of 2 No 1	fere eutopsy findings railable prior to mpletion of cause death?
To Be Completed by	examiner? 1	ont 3 DOA Other: 4 Voluming: 28c. Injury et Work? 1 Yes 2 No	performed 1 Yes eath (Check only one) Home 5 Residence	6 Other (Speci	Pere eutopsy findings railable prior to impletion of cause death?
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edical Certification: To Be Completed by	examiner? 1 Yes 2R No 1 Hospitel: 1 Inpatient 2 EP/Outpatien 17. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 5 Determined 28e. Plece of Injury - At home, Iarm, stripullding, etc. (Specify)	nt 3 DOA Other: 4 Nursing of 28c. Injury et Work? M 1 Yes 2 No reet, lactory, office th occurred et the time, date and place vestigation, in my opinion, death occurred.	performed 1 Yes Peath (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Str	6 Other (Special jury occurred and Number or Runste) (s) and manner as s	lere eutopsy findings railable prior lo impletion of cause death? Yes 207 No Yes 207 No
edical Certification: To Be Completed by	examiner? 1	nt 3 DOA Other: 4 Nursing of 28c. Injury et Work? M 1 Yes 2 No reet, lactory, office n occurred at the time, date and place vestigation, in my opinion, death occurred 29c. License number	performed 1 Yes eath (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Ste e, end due to the cause urred et the time, date a	6 Other (Special Special Speci	lere eutopsy findings railable prior to impletion of cause death? Yes 207 No Yes 207 No All Route Number, stated. o the cause(s) Dey, Year)
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Medical Certification: To Be Completed by	examiner? 1 Yes 2R No Hospitel: 1 Inpatient 2 EP/Outpatien 27. Manner of Death Netural 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Certifier (Check only one) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Signature and title of certifier 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Signature and title of certifier 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify) 28c. Plece of Injury - At home, larm, string the building, etc. (Specify)	nt 3 DOA Other: 4 Nursing of 28c. Injury et Work? M 1 Yes 2 No reet, lactory, office n occurred et the time, date and place vestigation, in my opinion, death occurred at the time of the control of th	performed 1 Yes eath (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Ste e, end due to the cause urred et the time, date a	6 Other (Special Special Speci	lere eutopsy findings rallable prior to impletion of cause death? Yes 27 No Yes 27 No Al Route Number, stated. o the cause(s) Dey, Year)



Please Type or Print in Black indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** ear7 December 19, 2000 ation of Death 4c. Country of Death 3:30 a.m. Jefferson homas /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number, **Examiner** Center ambridge Dorchester Mallard Bay Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Sex 100 M 20 F Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 266-24-4539 Dec. 07. 1425 Geor Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Director ambridge Dorchester 10g. Citizen of Whet Country? 10e. Street and Number 6 USA erried 12 Wes Decedent Ever in U.S.

Armed Forces?

1 12 Yes 2 \(\) No

11 Yes, Give

Year or Detes: 1944-1946 21613 238 Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Merried Maryland 21215-0020 1□ Yes 212 No 6 Specify: Black Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pagas 1 and 2 should be filed within: nant of Haalth and Mental Hygiene. int: If item 27 ie marked other than "i I Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) Assistant Onstruction 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Johnny eart 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a important: If Itam 27 is any injury or other tra-Lillian 244 Toni Street-Or lando. Florida Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Cemetery 12/21/2000 HURLOCK, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) HOME P.A. 22. Name end Address of Pircility 21. Signature of Funeral Servica Licenses Funeral 23a. Fail. Enter the disease, or complications that caused the death) Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate

Approximate HENRY Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Arterio Sclerotic heart disease Years Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of) Box 68760. Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Be Completed 2 PNo 1 Yes or Attending Physicien: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1□ Yes 212 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) Medical Certification: To 28a. Dete of tnjury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28c. tnjury et Work? Division 5 Pending investigation 1 Neturel after death. 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 T Homicide To the Hospital within 24 hours a To the Funeral C 112 Certifying Physictan: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steled. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signeture and title 29c. License number 12/20/00 M.D 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) St. Cambridge, md. 2/6/13 Af 20 Muhammad 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State DEC 2 0 2000 Registrar

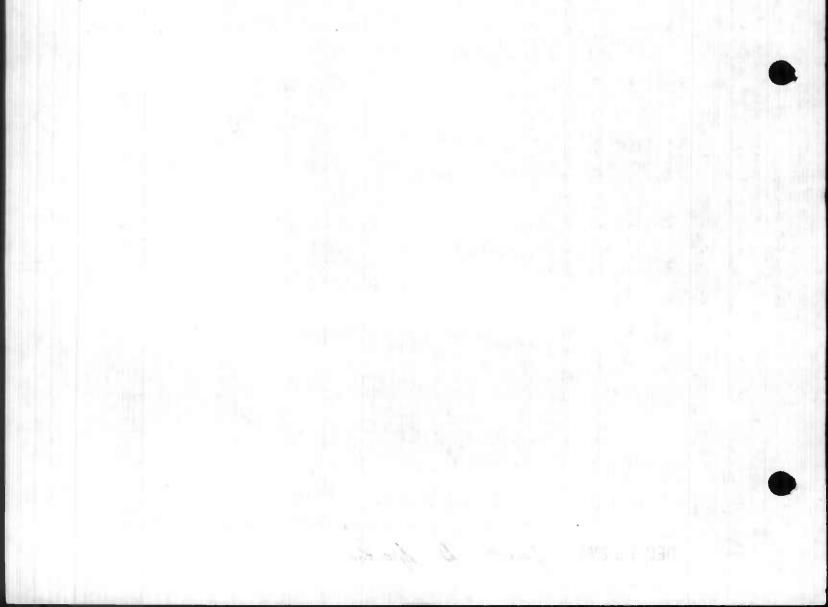
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п	Physicia	n	1. Decedent's Nem									2. Dete of De Month	4-2000	Year		ne of Death
	/Medica		Vance Ho							45.0	City, Town, or Lo			(D 4	07:4	DAM
4	Examine	r	4e Fecility Neme (I		111	et and numb	oer)				umberla					
-	Comment		5. Social Security N		6. Sex	7	. Age (In yrs.	lest birthdev)	If Under 1 Yea		Under 24 Hrs.		h Acc	egan	#	tete or Foreign
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	th with th	Funeral Director	5817 Cur		nd Hig	ghway			10f. Zip Code 15552				10g. Citizen of USA	Whet Co	untry?	
020	urs a	2	11. Meritel Status 1 Never Merri 3 Widowed	, ,	rried	Wes Deced Armed Forc 1 Tes 2 If Yes, Give Yeer or Det	No		Vas Decedent of Yes, specify Cu		inic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - Ame ick, White iy: Whi		on,
21215-0020	c ' m .	Сощріете	(Special Special Speci	ify only high		on <i>mpleted)</i> College (1-4	4or 5+)	(Give I		cupation ne durir ired)	n ng most of work	ing	16b. Kind of B			
	filed with Hygiene. Ither than		17. Father's Name	(First, Middle	, Last)			Farm	er	18	. Mother's Name	e (First, Middle,	Agricu Maiden Sumar		e.e	
land		0 00	Leroy Ru	INNORR	Тлоца	tman					Charlot					
Mary	2 should end Men is marke eumatic	-	19a. Informent's Na					19b. Mailin	g Address (Stra		Number or Rure			-	(ip Code)	
	and 2 palith of tre		Margare	t E. T	routmo	an, sp		5817	Cumberl	and	Highwa	y. Meye	rsdale.	PA	155	52
Baltimore,	Pages 1 end ent of Health ht: If item 27 ry or other to		20e. Method of Disp 1X Burial 2 4 Donetion	☐ Cremetion		ovel from St	ate	Plece of Disposementery, cremits Cem	sition (Neme of netory or other p	olace)		Dete	20c. Location O Well	- City or		
alti	permit, Page Depertment of Important: If eny Injury or pnce.		21. Signature of Fu				1000		. Name end Add	dress o	1		· wood	.000	weg,	
Ö	Dep		1 Hon	10011	17	- al	an)	На	rvey H.	Ze	igler F	uneral	Home, H	lyndm	ian,	PA
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68760,	ite be nysick he bu	edicai	Cause (Disease or that initiated events resulting in death)	injury	C	6	Due to (g	es e consedi	Jence of)	All	050		0.11	1	10	10
	ng pt		resulting in death)	L 0 3(-	
Box	attending p	any			d											
P.O. E	that the death certificate be executed ed by the attending physicien and detached for use as the bunal-transit	Physician	Pert II. Other signif	Icant condit	ions contrib	uting to dea	th but not resu	ulting in the un	derlying cause	given i	n Pert I.	23b. Did	tobacco use co		to the ca	use of death?
of Vital Records,	The lew requires that the de te has been signed by the s page 2 should be detached	Completed by		trie 1	Panch	last.	(Cost	e) -110	of an	Are	rie .		en eutopsy med?		aveilable p	opsy findings prior to on of cause
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E	The k											10	Yes 2 No		1 🗆 Yes	2□ No
Vita	s cartificate director, pag	0	25. Wes case refer examiner?		al Hose	nite!				Other:	S. Placa of Deat					
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Division	after death. Director: A d in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could	1 not be	28a. Place o building	of Injury - At ho g, etc. (Specify	oma, farm, stre	eet, factory, office	се		28f. Location (City or To	Streat end Num wn, Stete)	ber or Ri	urel Route	Number,
	To the Hospital or Attanding Ph within 24 hours aftar death. To the Funerel Director: Aftar th completely filled in by tha funeral	edical	29a. Certifier (Check only one)	1 Certify 2 Medica	ing Physicia I Examiner:	en: To the b	is of examinat	wledge, daeth tion end/or inv	occurred at the estigation, in my	tima, o	data end piece, on, deeth occurr	and due to the red at the time,	ceuse(s) end m date end plece,	enner as	steted.	use(s)
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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Dey Month **Physician** 9:30AM WILLIAM OSCAR TWIGG December 24 2000 /Medical 4b. City. Town, or Location of Death 4a Facility Neme (If not institution, giva street end number) 4c. County of Death Examiner ALLEGANY CUMBERLAND SACRED HEART HOSPITAL If Linder 1 Year | If Linder 24 Hrs 8. Date of Birth (Month, Dey, Year) AUG 4 1917 Birthplece (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Hours Months Deys Vrs Director 217 14 4300 83 MARYLAND Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location filed within 72 hours after death with the Marylan Hyglens. Hyglens, or items 23a or 28a-f show ent, the Marylan Entering man be notified at 10d. Inside City Limits 1 Yes 2 No Director MARYLAND ALLEGANY FROSTBURG 10f. Zip Code 10e Street and Number 10g. Citizan of What Country? 152 GREEN STREET 21532 U.S. Funeral 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) MAINTENANCE UNIVERSITY 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health end Mentel H WILLIAM FRANCIS TWIGG, SR. EDITH BRINKMAN 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) DIANA SIPPLE / DAUGHTER 91 BOWERY ST., FROSTBURG, MD 21532 Department of Health Important: if Item 27 any injury or other to 2008. Baltimore, 20b. Plece of Disposition (Nema of cemetery, cremetory or other piece) 20e. Mathod of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cremetion 3 Ramovel from State THE CUMBERLAND CREMATORY 12/25/00 CUMBERLAND, MD 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility SOWERS FUNERAL HOME, P.A. 23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or raspiretory errest, shock, or haart failure. List only one ceuse on each line. Approximete Intervel Batween Onset end Death **Physician** acut Large Right intraparyndymal Parietal Immedieta Causa (Finel disease or condition resulting in deeth) /Medical Examiner 4 Lays Hemorrhage with Ventricular extension Examine ettending physician and for use as the burial-transit death certificate be axecuted Sequentielly list conditions, if any, laeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury Due to (or es e consequence of) Physician/Medical that initiated avents resulting In deeth) Lest Dua to (or as a consequence of): detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Onknown Hypertension by 24b. Were autopsy findings available prior to complation of ceuse of deeth? 24a. Wes en eutopsy performed? Completed director, page 2 1 Yes 25 Alo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) examiner? Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 76 0 Certification:

Box 68760. Division of Vital Records. Physicien: this I or Attending P Director: / To the Hospital of within 24 hours all To the Funeral D completely filled in

27. Mennar of Death 28b. Time of 28d. Describe how injury occurred Injury Nature 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data end place, end due to the ceusa(s) 29a. Certifier

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29b. Signeture end title of certifier em 721244

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29d. Date signed (Month, Dey, Year) 29c. Licansa number

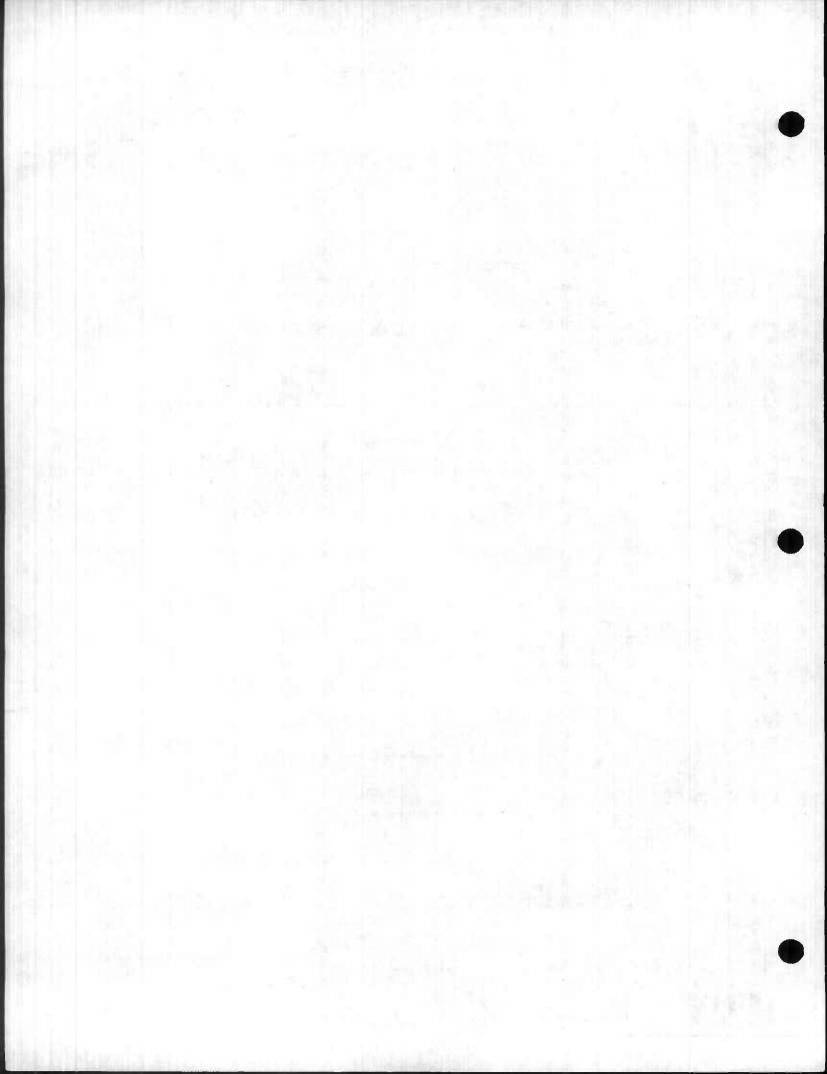
December 242000

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

JESUS H. TAN, M.D., FROSTBURG PLAZA, FROSTBURG, MD 21532

State Registrar 31. Data filed (Month, Day, Year) 32. Registrer's Signeture DEC 2 6 2000 Deperson

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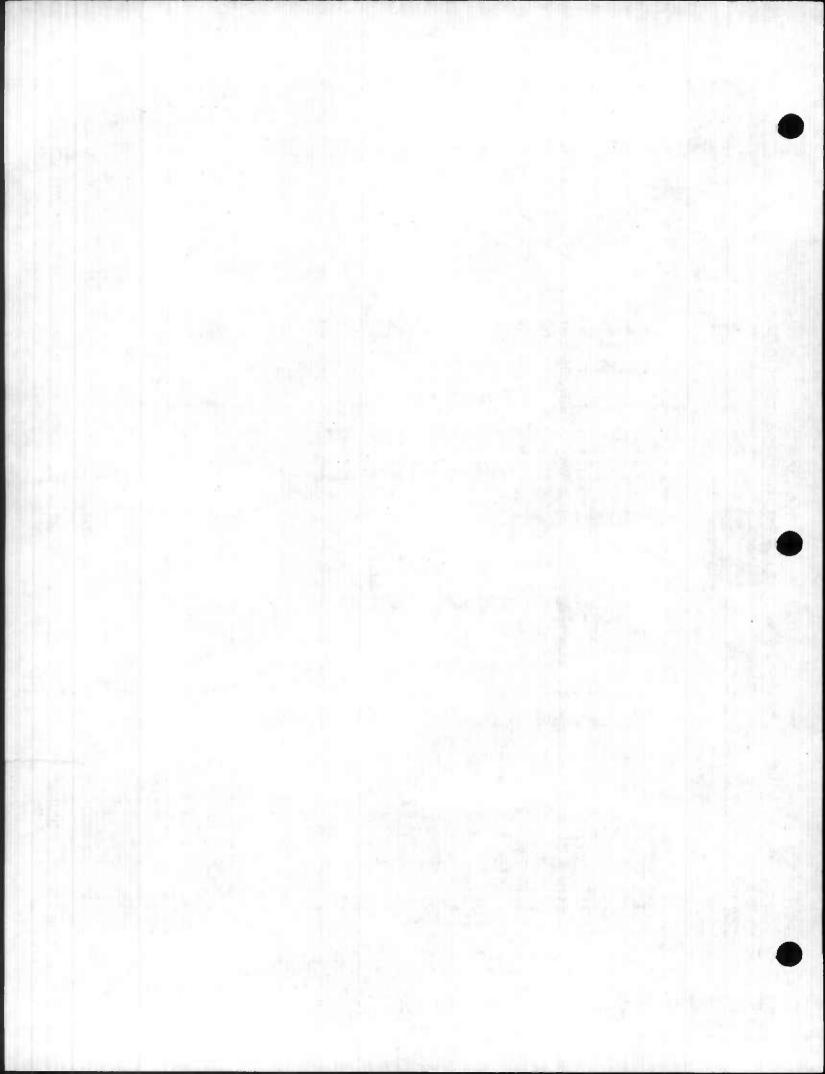


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Yeer Month **Physician** December 20, Maria Manola Vila 2000 8:25 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Hospice- Casey House Montgomery 8. Date of Birth (Month, Dey, Year) Feb 12, 19: If Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Deys Hours Yrs. 61 1939 Director 578-76-7041 Spain Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mantal Hygiene.
7 is marked other than "natural", or fierra 23a or 28a-f show traumatic event, the Mantal Examination must be inclined at 1 ☐ Yes 2X No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 4529 Chestnut Street 20814 Funerai deeth Spain 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 Z No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked othe eny injury or other treumatic event, bince. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Carmen Perez Jose Maria Lorenzo-Dopazo 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 4529 Chestnut Street, Bethesda, MD 20814 Jose Luis Vila / Husband 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 12/23/00 Coruna, Spain Parroquia de Mino 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture of Funerel Service Licenses Francis J. Collins Funeral Home, Inc. 23a. Pert1. Enter the disease, or complication, thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiretory errest, intervel Between Onset end Deeth MD 20901 **Physician** Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical 6 months Metastatic Cancer Examiner Due to (or es e consequence of): Examine Colon Cancer 18 months physicien and s the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of) for use as t signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records. þ 24b. Were eutopsy findings available prior to completion of ceuse of deeth? been si Completed 24a. Wes en eutopsy performed? director, page 2 : 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Wes cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospice 70 1 Yes 2 No this funeral 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28c. Injury et Work? 28b. Time of Certification: After 5 Pending investigation 1 X Naturel death. 1 Yes 2 No Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) eftar 4 | Homicide To the Hospital o within 24 hours aff To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29a. Certifier edical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 4 MD 10 D 09470 December 21, 2000 30. Neme end eddress of person who completed ceuse of death (Item 23a) (Type, Print) 10400 Connecticut Ave E.P. Libre, MD Kensington, MD 20895 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Denne DEC 22 Registrar



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 12/11/ 2000 10:30pm MARY M. WADDY /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner REGENCY NURSING CENTER FORESTVILLE P.G. COUNTY If Under 1 Yaar | If Under 24 Hrs. | Months | Deys | Hours | Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplaca (State or Foreign Country) **Funeral** 10 M 20 F Deys 577-24-3143 Director 05/18/1918 MARYLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. P.G. CAPITAL HEIGHTS 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5037 GUNTHER ST. 20743 U.S.A. 12. Was Decedent Ever in U,S. Armed Forceş? 1 ☐ Yes 2 Ø No If Yas, Giva Yeer or Detes: 14. Rece - American Indien, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 □ Widowed 4 ₺ Divorced þ Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CLERK FEDERAL GOVT 17. Fether's Nema (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumama) SPRINGFIELD SPENCER MILDRED HENRY 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JOSEPH SPENCER (SON) 5037 GUNTHER ST. CAPITAL HEIGHTS MD. 20743 20b. Placa of Disposition (Neme of cemetery, cremetory or other place 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Burlel 2 Cremetion 3 Ramoval from Stete MT. OLIVET CEMETERY 12/18/00 MASHINGTON D.C. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee AUS) IN ROYSTER FUNERAL HOME 3821 14th ST. N.W. WASH. D.C. 23a. Part. Enter the disease or complications that caused the death. Do not offer the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical Sepsis Examiner Due to (or es e consequence of): Physician/Medical Examine Dine Jmonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Que to (or es e consequence of): thet initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2010 3 Probably 4 Unknown Dementia, urinary tract infection by 24b. Were autopsy findings 24a. Was an eutopsy Completed Infected dewbitus vicers availabla prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical axeminer? Be 28. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Horsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Deta of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Tima of 5 Pending investigation 1 Canaturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rurei Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. edicai 29a. Certifier

The law requires that the death certificate be executed signed by the attanding physician and id be datached for use as the bunal-trans Division of Vital Records, P.O. Box 68760, has been signed 2 should b or Attending Physician: this after death.

| Director: After this d in by the funeral d I led in I To the Hospital c within 24 hours at To the Funeral D completaly filled is

thems 23s or 28s-f show ther must be notified at

the Medical Examiner.

Pages 1 and 2 should be ment of Health and Mental ant: If Rem 27 to marked or

Baltimore,

ould be Mental

29b. Signatura and title of certifian George C.

29c. Licensa number 039550 29d. Data signed (Month, Dey, Year) 12-14-00

30. Neme and address of person who complated ceuse of death (Item 23a) (Type, Print)

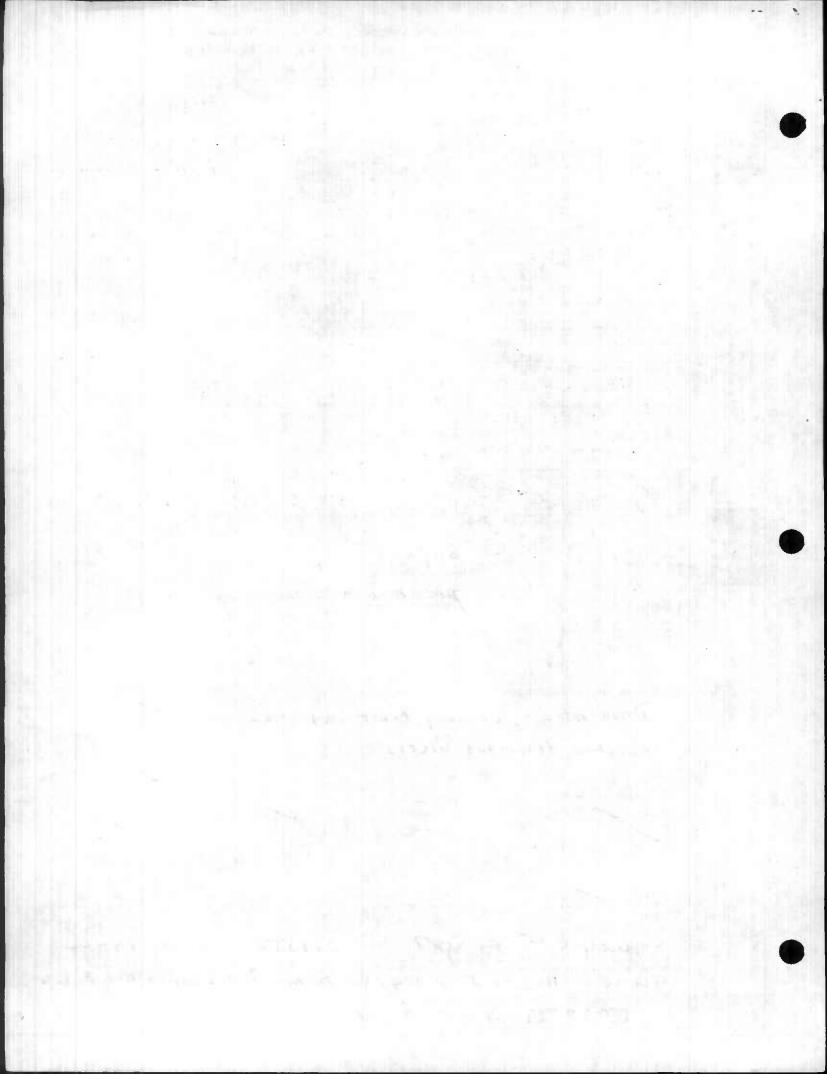
Hajjar, Jr. m.D. 4850 Forbes Blud Lanhan, Md 20706

Registrar

31. Deta filed (Month, Dey, Year)

DEC 18 2000 32. Begistrar's Signature Down

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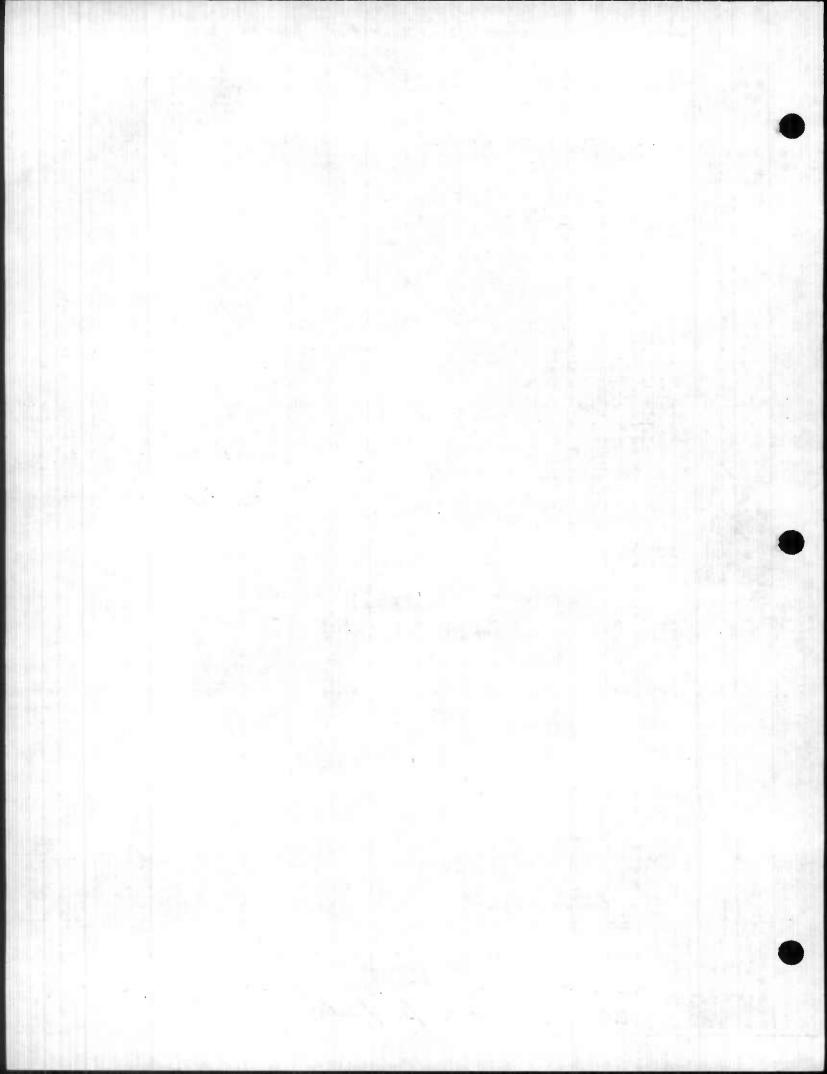
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 0 4 2 2 4

			C	ertificate	e of I	Death		Re	eg. Nó.	46	249
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	Montgomery Ge	eneral Hos	pital			01:	ney		MO	ONTG	OMERY
Funeral	5. Social Security Number 6		(In yrs. last birthda	y) If Under Months	1 Yaar Days	If Under Hours	24 Hrs.	8. Data of Birth (Month, Day,	Year)	9. Birthp	laca (Stata or Foraign
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 440 Month Daniel F. Walsh 2000 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) MONT Bethesda MD HOSP If Under 1 Yaar | If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Days Months M 20 F 79 Yrs. 577-28-6169 May 24, 1921 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Maryland Montgomery Potomac 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 8509 Atwell Road 20854 USA 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14, Race - Amarican Indian, 11, Marital Status Black, Whita, atc. 1X Yas 2 No If Yas, Giva Yaar or Datas: WWII 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Real Estate Broker Real Estate 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Michael Walsh Catherine Lane 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Rita M. Walsh / Wife 8509 Atwell Road, Potomac, MD 20854 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cramation 3 Removal from Stata Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/18/00 Silver Spring, MD 22. Nama and Addrass of Facility 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart tailure. List only one ceuse on each line. Francis J. Collins Funeral Home, Inc. MD 20901 500 University Blvd., W, Silver Spring, Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) tension pneumothorax day Dua to (or as a consequence of): weeks respiratory Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseasa or Injury that Initiated avants rasulting in death) Last weeks pneu moma Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yas 2 ☐ No 1 TYas

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier

29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

9707 Medical Center Drive # 300 Rocharille, MD 20850 GERRIE A. SOIDS, MO 31. Data filed (Month, Day, Year)

State Registrar

DEC 1 8 2000

32. Registrar's Signatura

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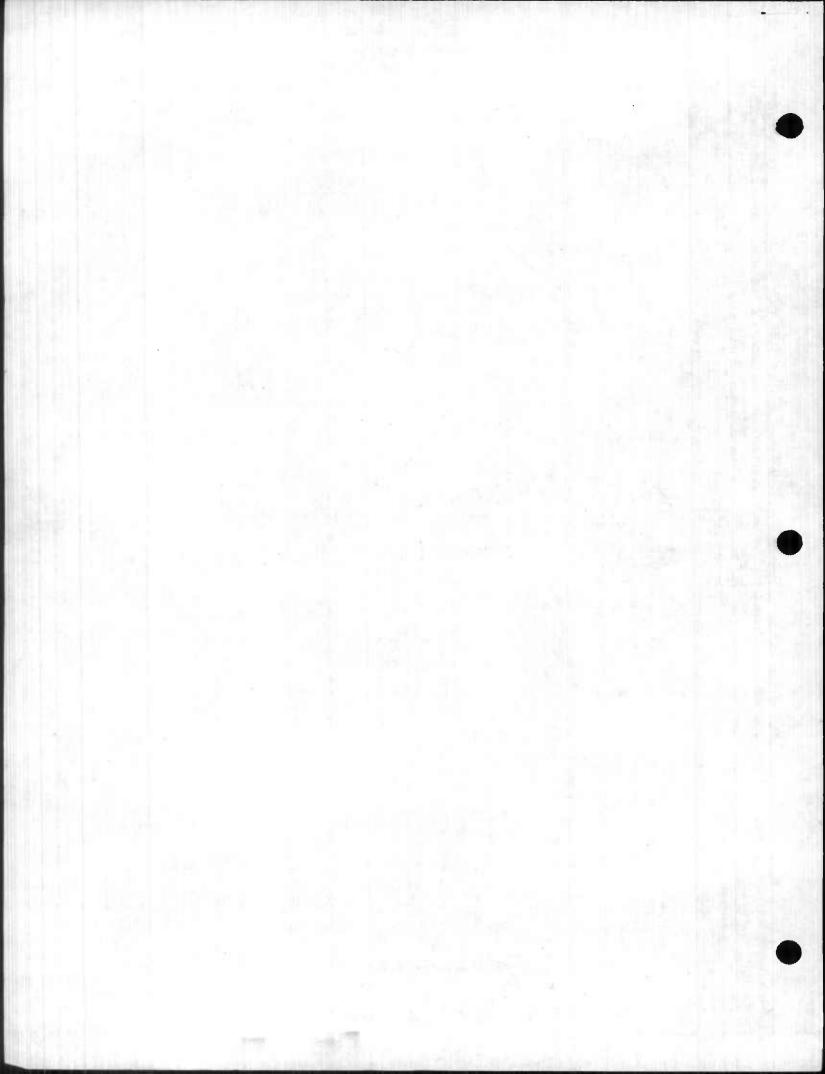
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State of Maryland / Department of Health and Mental Hygiene | 1, 2 2 5 |

Certificate of Death

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Funeral	5. Social Security Number 6. Se	7. Age (In	yrs. last birth	day) If Under 1 Ye			rth ev. Year)	Cou	place (Stete or Foreign	
Director		M 20 F	96 Y	rs.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	JAN 8,	1904	NEW	YÖRK	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death Month DEC. **Physician** WHITE 16, 2000 3:55 PM **JACOB** ERWIN /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY Silver Spring Holy Cross Hospital 5. Social Sacurity Number If Undar 1 Yaar | If Under 24 Hrs. Birthplace (Stata or Foreign Country) 6 Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 15 Months Hours 11X M 2□ F Yrs. Maryland Director N/A 2000 Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits than "natural", or frame 23a or 28a-f ahow the Medical Examiner must be nothed at 1 ☐ Yes 2 No Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20879 U.S.A. 12 Mountain Laurel Court Funeral death 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black. White, etc. 72 hours after 1€ Never Married 2□ Married Black 1 ☐ Yes 2 XNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp completed) filed within Elementery/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 18 Mother's Name /First Middle Maiden Surname 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental.) Important if Isen 27 is marked oil any Injury or other 88 Mental Mental Erwin White Michelle Johnson 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20879 19a. Informent's Name/Relationship (Type, Print) Gaithersburg, 12 Mountain Laurel Ct., Erwin White (Father) Saltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Denation 5 ☐ Other (Specify) 12/22/00 Gaithersburg, MD Emory Grove Cem. 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. 2). Signature of Eugeral Service Lice 20850 246 N. Wash. St., Rockville, MD 23a Part Enter the gleasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart flours. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner signed by the attending physician and if be detached for use as the bunal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 25 No 3 Probably 4 Unknown by Division of Vital Records. The law requires 24b. Were autopsy findings available prior to should t 24a. Was an autopsy performed? Completed completion of cause of death? page 2 this certificate has 1 Yes 1 ☐ Yes 2 ☐ No Physician: Be eral Diractor: After this certific filled in by the funeral director, 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yas 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28d. Describe how injury occurred Attanding 1 Natural 5 Pending invastigation 1 Yes 2 No deeth. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) or A after 4 Homicide Hospital of To the Hospital
within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Dey, Year)
DEC 2 1 2000

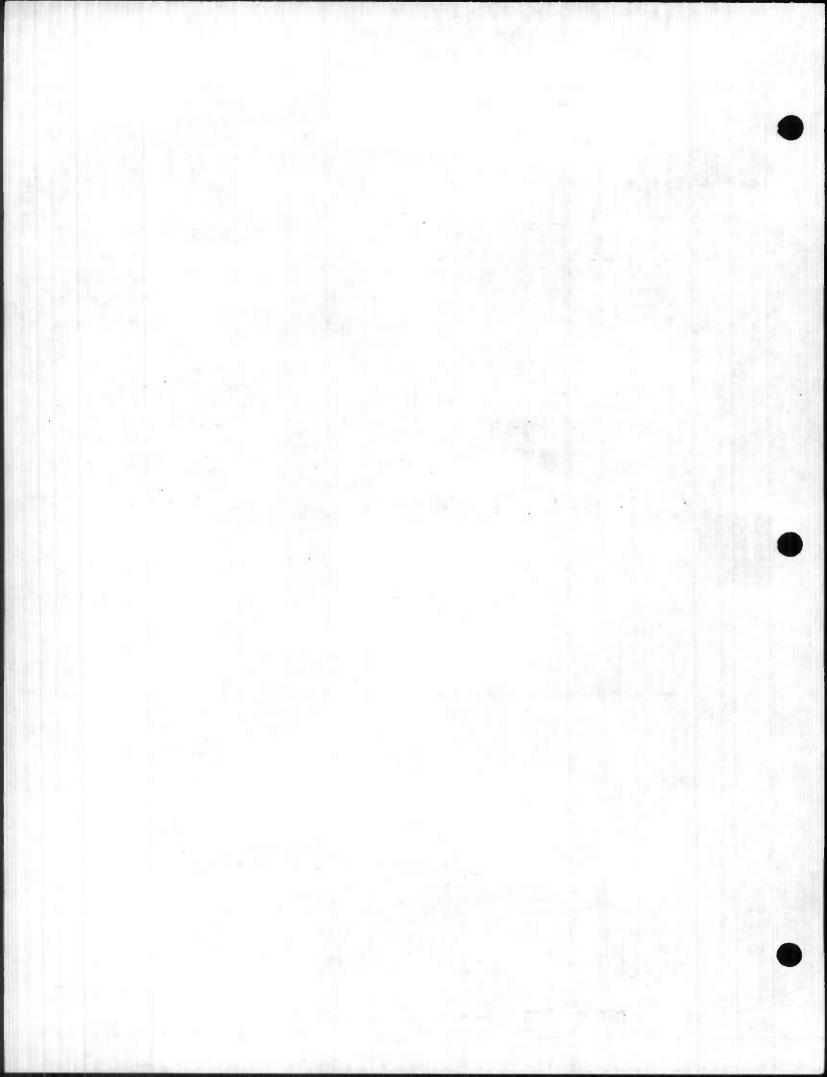
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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		4704 Locust Hill	Court					Bethesda			ontgo	
Funera Directo			Sex 1□M 2√2 F	7. Age (In)	yrs. lest birthdey) Yrs.	If Under 1 Months	Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De) Dec. 21	Year)	Cour	place (Stete or Foreign atry) Vland
		Usual Residence of Decedent		,	•				Dec. 21	, 1923	Mai	yland
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or 28	Director	10e. Street and Number				10f. Zip C	Code			10g. Citizen of \	Whet Cour	ntry?
th wi		4704 Locust Hill	Court			20	814			United	Stat	es
de E	Funerai	11. Marital Status	12. Was Dec		n U,S. 13.	Was Decede	nt of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-	14. Rac	a - Americ	
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8 5 2 2		20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 [☐Removel from	State	b. Plece of Disponentery, cre				Dec. 18,	20c. Location -		
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permit. Page Department of Important: If I any Injury or		21. Signeture of Funeral Service Lice	ensee	MO	0198	obert 557 Wi	Addres LSCO	Pumphrey nsin Ave Maryland	Funeral nue 20814-	Home/I	Bethe Chas	sda-Chevy e, Inc.
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1 E	· 65	Cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	c	Due t	o (or es e conse	quence of):		7	17			
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tha death y the etter	/sic	Pert II. Other significant conditions	contributing to d	deeth but not	resulting in the	underlying ca	use give	en in Part I.	23b. Did 1	obacco uae co	ntribute t	o the cause of death?
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v requires that been signed t	ted by			112					24a. Was	en eutopsy med?	av	ere eutopsy findings
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	atio	1 ☑ Netural 5 ☐ Pending Investigation	on		, ,,,,,,,	М		Yes 2□No				
1 2 E E	Certification:	3 Suicide 6 Could not determined	200. Pleci	a of Injury - A	At home, farm, st ecify)	reet, factory,	offica		28f. Location (: City or Tox	Street end Numi vn, State)	ber or Aun	al Route Number,
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		78	and the	-)115			Decembe		
25		30. Name and address of person who	completed cau	se of death	(Item 23a) (Type							
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State Registrar

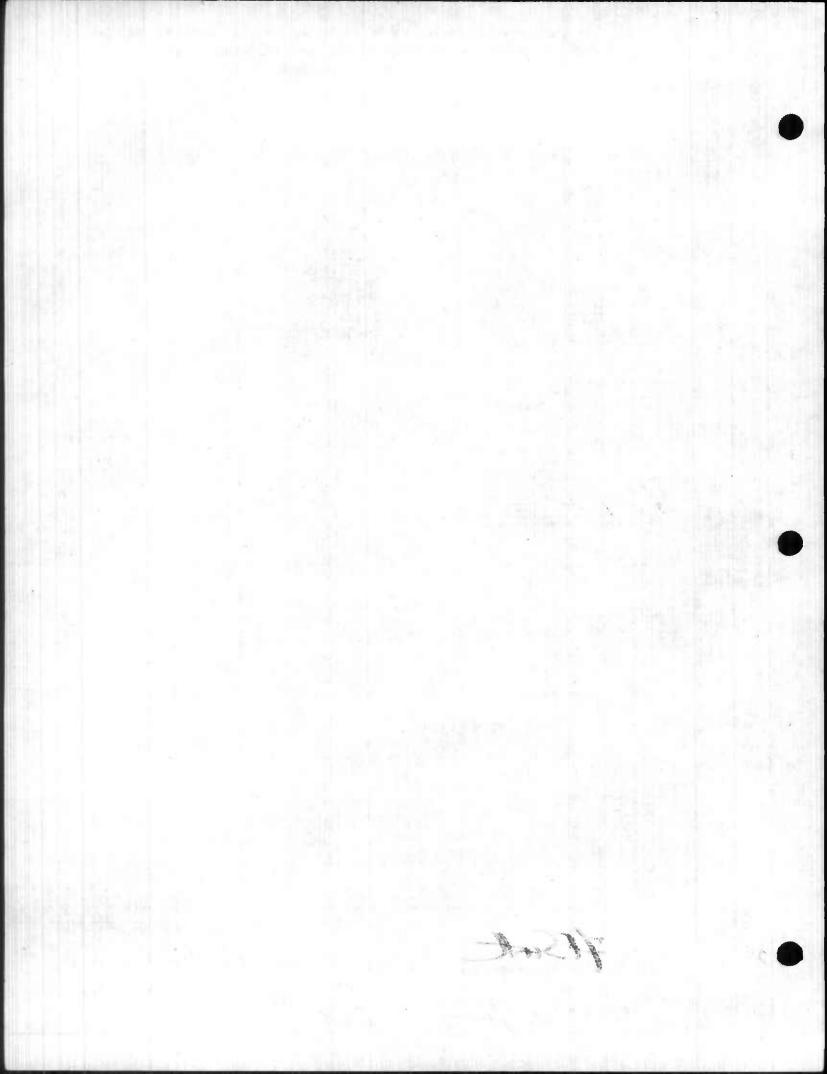
Frederick P. Smith, M.D. 5401 Western Avenue, N.W. Washington, D.C. 20015

31. Dete filed (Month, Day, Year)

DEC 19 2000

32. Begistrar's Signature

B. Apauls



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death DECEMBER 16,2000 **Physician** 13:15 HOMER **EDWARD** WILL JAMS /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 13118 LUTES LANE SILVER SPRING MONTGOMERY If Under 24 Hrs. 8. Dete of Birth JULY 14, 1933 5. Sociel Security Number 9. Birthplace (State or Foreign MISSISSIPPI 7. Age (In yrs. lest birthday) **Funeral** 15 M 2□ F 67 Months Deys Hours 214 34 6363 Director Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show tem 27 te merked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MONTGOMERY MD. SILVER SPRING 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 13118 LUTES LANE 20906 UNITED STATES Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ⑤ No It Yes, Give Yeer or Dates: 13. Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Ie merked other than any Injury or other traumetic event. the Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE HANDICAP CENTER 17 Fether's Name /First Middle Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be HOMER WILLIAMS MYRTLE **EDWARDS** 19a. Intermant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JOHN B. WILLIAMS, BROTHER 25012 SILVERCREST DRIVE, GAITHERSBURG, MD. 20882 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece)
METROPOLITAN CREMATORY 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 SCremetion 3 ☐ Removei from State 12/17/00 ALEXANDRIA, VA. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licensee PHURTER AMPROSS BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximete intervei Between Onset end Death **Physician** cardiovas cular disease /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest and Due to (or es e consequenca ot): certificate be execu Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical Due to (or es e consequence ot) USB as 23b. Did tobacco use contribute to the cause of death? been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2000 3 □ Probably 4 □ Unknown 1 Yes p 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy has 20 No 1 Yes 1 Yes certificate 25. Was case reterred to medical Be 28. Piece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: After 5 Pending investigation Naturel 1 Yes 2 No death. 2 ☐ Accident Hospital or Attendi 24 hours efter death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
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completely filled Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

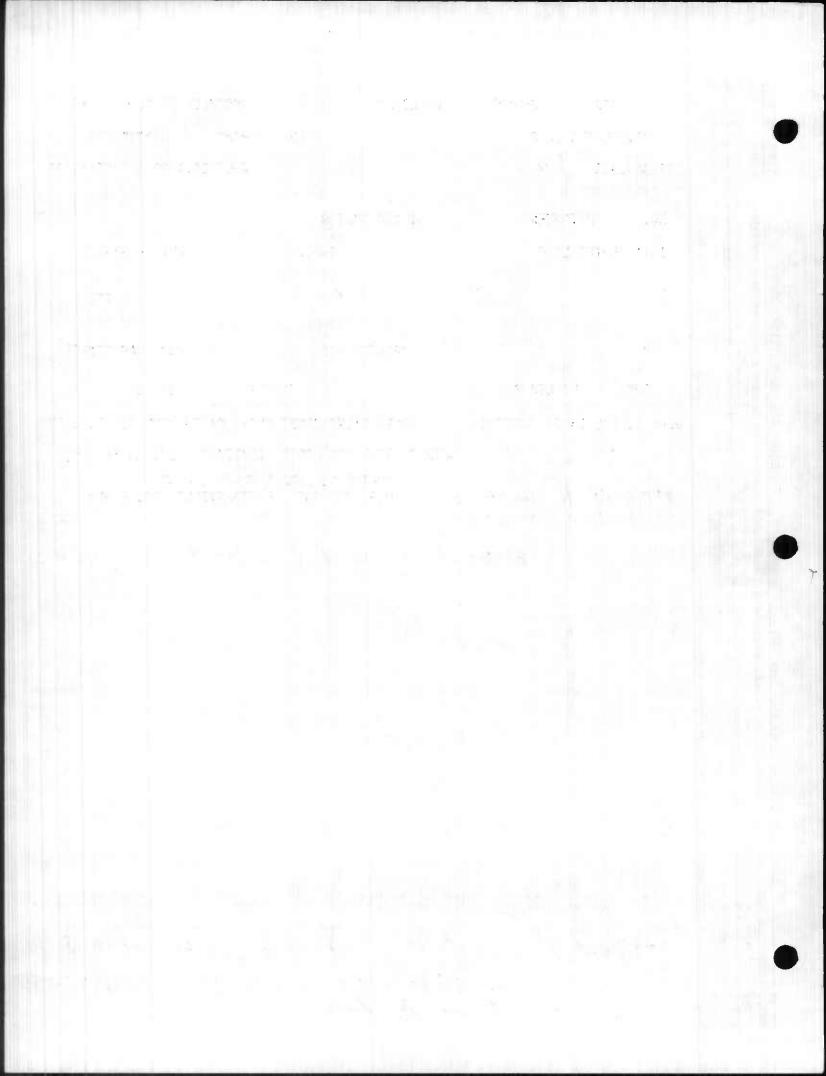
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29c. Licanse number 29b. Signeture end title of cartifier Rockville Pike, PMB348, Rockville, MD 20 852 31. Dete tiled (Month, Day, Year) strer's Signeture State

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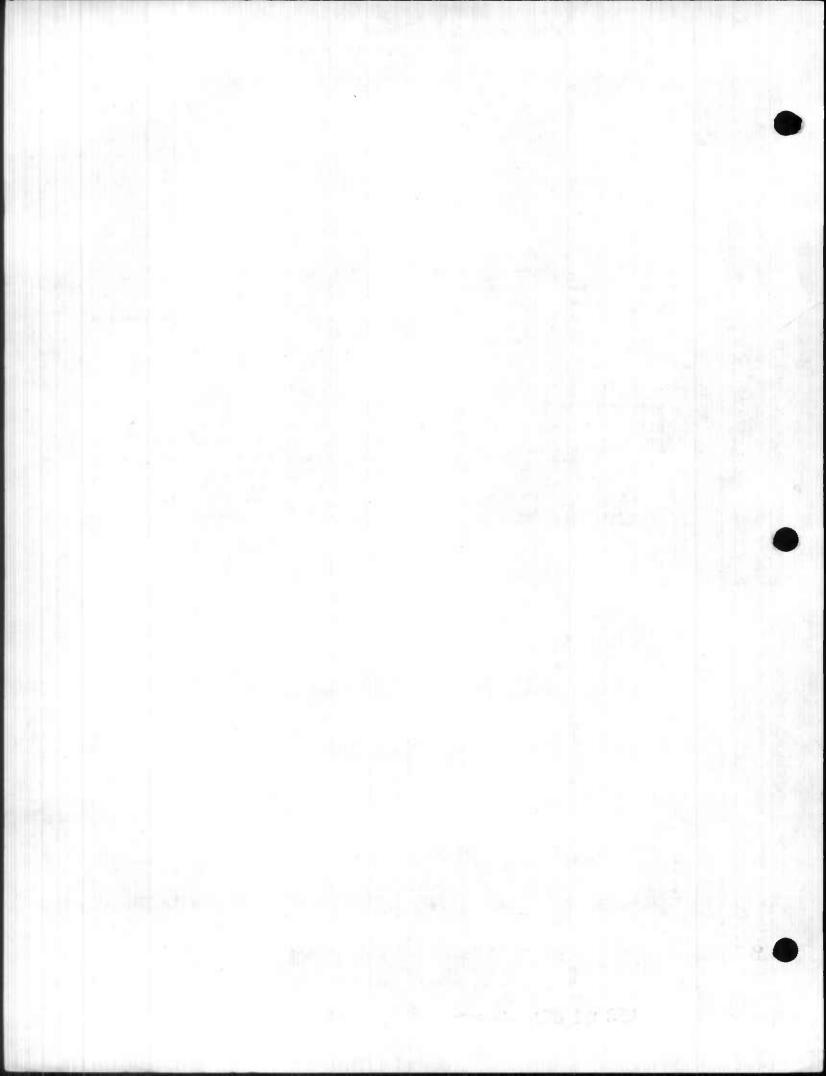
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year Physician Dorothy Hazel Wright December 18, 2000 8:16 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Brooke Grove Nursing Home Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 29, 1 5. Social Security Number Birthpleca (State or Foreign Country) 7. Age (In yrs. last birthday) **Frineral** Months Days Hours 1□M 2⊠F Yrs 579-44-2881 87 1913 Maryland Director Usual Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Montgomery Colesville Director 28a-f must be notif 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? ò 14708 Pebblestone Drive 23a 20905 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 1 Yes 2 No If Yes, Giva Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0020 ь 1 Yes 2 No Specify: Specify: à USA 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) 12 College (1-4or 5+) Office Manager American Forestry Assoc. Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be marked or Arthur Hill Myrtle Redden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an art: If Nem 27 Is: Norman Sheetz / Son 14708 Pebblestone Drive, Colesville, Maryland 20905 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 Burial 2 □ Cremation 3 □ Removal from State b 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park 12/21/00 Rockville, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licenses 11800 New Hampshire Avenue Wonnell alan Silver Spring, Maryland 20904 23a. Part1. Enter the disease, ex-complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting in deeth) Phermana /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last use as the burial-trar Dua to (or as a consequence of) Box 68760. Due to (or as a consequence of): P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown of Vital Records. þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2€No 1 Yas 2 No this certificate al or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, pi Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manney of Death Division 1- Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital c within 24 hours a To the Funeral D 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Cartifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of cadities Decomber 18, 2000 A39793 9 aysun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgia de Woodar, uno 20202 J. Mays ma pher 12102 31. Date tiled (Month, Day, Year) 32 Megistrar's Signature State

Registrar

DEC

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 42257 Certificate of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** Mabel Willetts 12 20 - 20008:00 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner Frostburg Allegany Frostburg Village Nursing Care Center Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 M 2 K F Deys Hours Yrs. 267-56-5278 88 Director Maryland 24-Dec-11 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ehow the Medical Examinat must be notified at 1 Yes 2 □ No Director Maryland Allegany Frostburg 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? **59 Mount Pleasant Street** Funeral 21532- Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritel Status permit. Peges 1 and 2 should be filed within 72 hours after of Depertment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or item any injury or other treumatic event, the Morre Estimate 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) minister 12 ministry 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Frank Willetts Julia Ann Skidmore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) David R. Willetts Frostburg Maryland 21532-20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State Frostburg Memorial Park 4 Donetion 5 Other (Specify) 23-Dec-00 Frostburg, Maryland 21. Signeture of Funerel Service Licensea. 22. Name and Address of Facility hu Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximete Intervel Between Onset end Death 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting In death) Cardio respiratory /Medical 1 HR. Examiner Physician/Medical Examiner sician and burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that the death certificete be execu physician s the burial 68760 that initieted events resulting in deeth) Lest Due to (or es e consequence of) 80 attending Box 950 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24e. Wes en eutopsy performed? 24b. Were autopsy findings Be Completed evailable prior to completion of cause of deeth? page 2 1 ☐ Yes 2 No this certificate of Vital 25. Was cese referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: Affer th completely filled in by the funeral 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stefe) 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number M 2000 120055325 Dec 21 5 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) WONSOCK SHIN, M.D., 204 TARN TERRACE, SUITE 204, FROSTBURG, MD. 21532 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State DEC 22 2000

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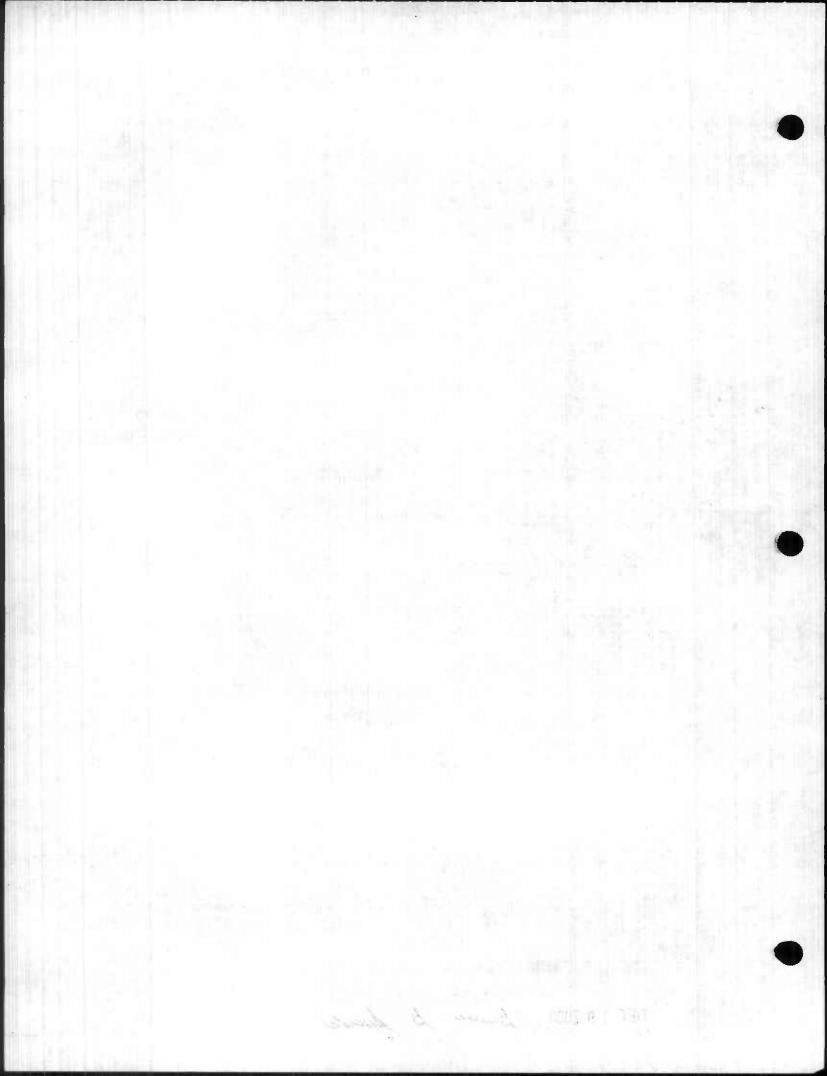
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Wisenburg Dec. 17, 2000 5:50 p.m. Willard /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Allegany Cumberland 705 Leiper Street If Under 1 Year If Undar 24 Hrs. 8 Date of Birth (Month, Day, Year) 916 Birthplaca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** M 2□ F Months Yrs. 705-12-4670 84 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Examiner must be r 21502 USA 705 Leiper Street Funeral 12. Wes Decadent Evar in U.S. Armed Forces? 1 △ Yes 2 □ No If Yes, Give Yeer or DateW II 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 Divorced / Hygiene. other then "natura rent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 College (1-4or 5+) Machinist Chessie System is marked other reumstic event, ti 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumame) permit. Pages 1 and 2 should be till.
Department of Heath and Mental Himportant: If fran 27 is marked oth any injury or other traumatic even Clara (True) James Wisenburg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
705 Leiper Street; Cumberland MD 21502 19e. Informent's Name/Relationship (Type, Print) Loretta Jones daught erosition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 12/20 20c. Location - City or Town, State Buriel 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Par2000 Cumberland, MD Hillcrest Memorial Scarpelli Füheral Home, P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) U SECONDS CARDIAC ARREST Examiner Due to (or as a consequence of): Physician/Medical Examiner 9 DAYS MYOCARDIO C INFARCTION ACUTE The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of). 23b. Did tobacco use contribute to the cause of death? ed by the deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown O BSTRUCTIVE LUNG DISGIAGE þ 24b. Wera eutopsy findings aveilable prior to completion of ceuse of death? been signated 24a. Was en autopsy performed? Completed DEPLESSION hes l page Is certificate h 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i Be 25. Was case referred to medice 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yas 20 No 10 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27. Mennef of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13eh M. 5 . DECEMBER 18TH 2,000 -D23334 mel yes 30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print) Dinesh Shah, M.D.; 625 Kent Avenue; Cumberland, MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State DEC 19 2000 Registrar

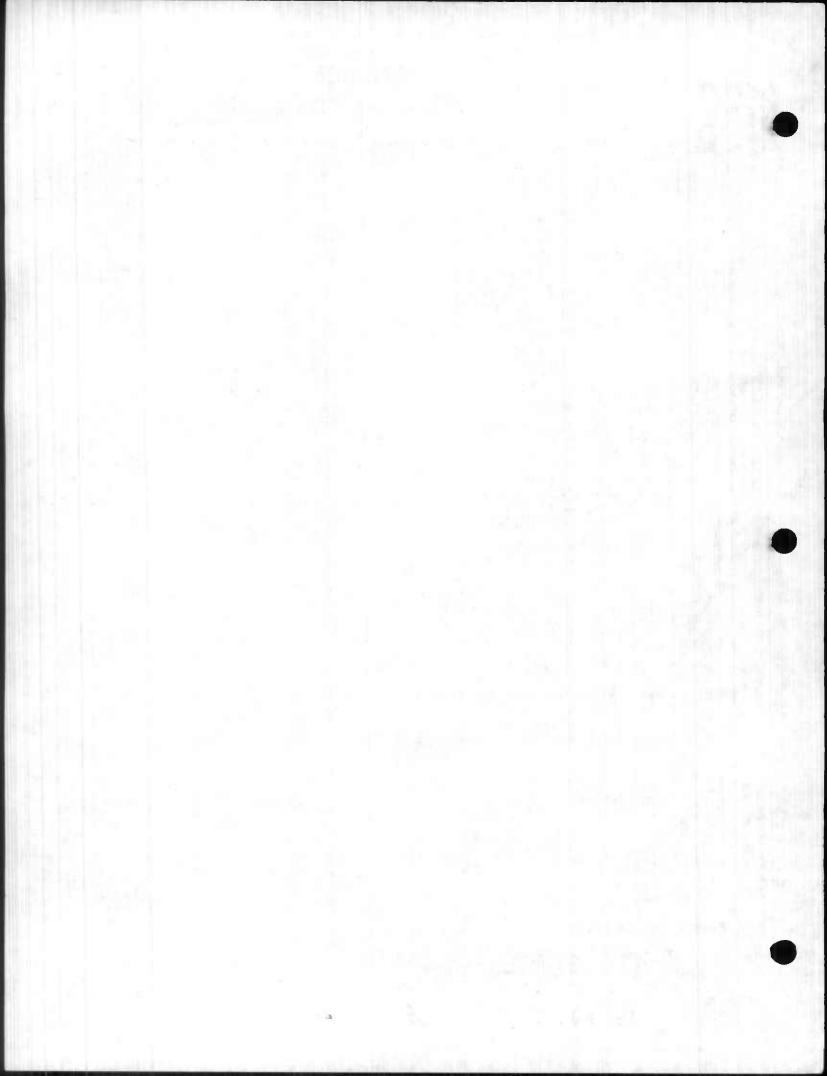
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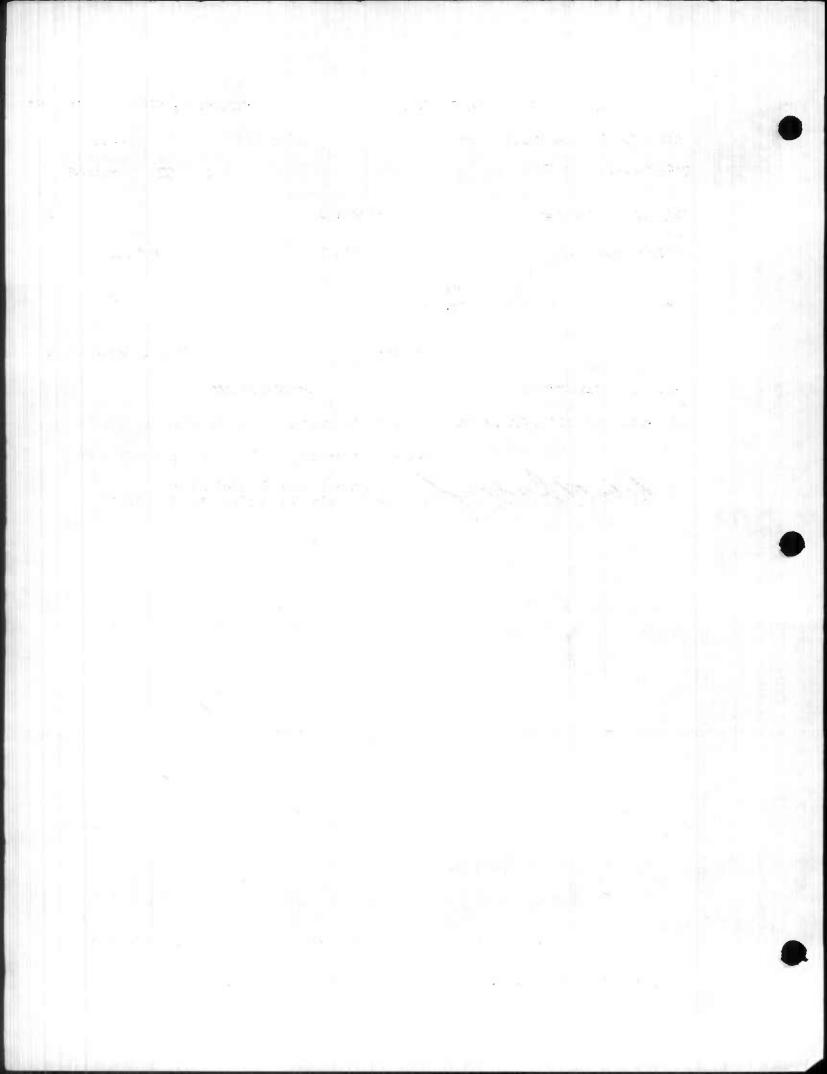
State of Maryland / Department of Health and Mental Hygiene

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al er	4a Facility Neme	Marjor	ie A. give street end num		mmer man		4b	. City, Town, or			nty of Death	0.47
r I	the particular states		age Care		hah		Mo	ntgomer	v Villa	Mont	comerv	
i	5. Social Security				last birthday)		r 1 Year	If Under 24 Hrs	8. Dete of E	0	-	aca (Stete or F
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	10a. Stete	10b. County		10c. Ci	ity, Town or Lo	cation					10	d. Inside City
	Maryland	Montgon	nerv	Ga	ithersb	ourg						1X Yes 2
	10e. Street and N					10f. Zip	o Code			10g. Citizen o	of What Count	ry?
	18700 W	alkers C	hoice Roa	ıd		20	0879			United	States	3
-	11. Merital Status		12. Wes Dece Armed For	dent Ever in U ces? 2 [X]No		Was Deced f Yes, spec		penIc Origin? (S , Mexican, Puer Specify:	Specify Yes or to Rican, etc.)	14. R B Spec	lace - America leck, White, e city: Whi	tc.
	(Sne	15. Decedent's ecify only highest			16e. Deced	dent's Usua	al Occupa	tion	rkina	16b. Kind of	Business/Ind	ustry
	Etementery/Sec		College (1-	4or 5+)				iring most of wo	g			
	12				Homen	naker				Own h	iome	
	17. Father's Name	e (First, Middle, La	st)					18. Mother's Na	me (First, Midd	lle, Maiden Sum	em <i>e)</i>	
	James A	Allen						Edna M	. Croc	k		
	19a. informent'a l	Name/Reletionship	(Type, Print)			_		nd Number or R				
	James C.	King (brother)		9901	Shrev	wsbur	y Court	Gaith	ersburg	, Md.	20879
	20a. Method of Di				Plece of Dispo- cemetery, cren	sition (Nar	me of other place	,	Dec. 18		n - City or To	vn, State
		2 lXiCremetion 3 5 ☐ Other (Spe	☐Removel from 5 cify)		ropoli	tan (Crema		2000	Alexan	dria,	Virgini
	21. Signature of F	Funeral Service Lic	censee	110	-			of Fecility				
	1 P.	+ C	1 has	1	1.0					neral H		1 306.
-	23a Parti Enter	the disease or or	omplications that cally one cause on ea	used the dea				Park Dr			urg, M	Approximate
E			0			quence of):	1711					
מפוכסו	Sequentially list of if eny, leading to cause. Enter Und Couse (Disease of that Initiated even resulting in death	NS .	b. <u>CON</u>	Due to (e Heart or as a conseq or as e conseq	Fail	lure :					
	I that initieted even	NS .	b. <u>Con</u> ;	Due to (or as a conseq	Fail	lure :					
	resulting In death	nts i) Lest	c	Due to (d	or as a conseq	Fail quence of):	lure :	n in Pert I.	23b. Di	id tobacco uae	contributa to	the causa of
	resulting In death	nts i) Lest	с	Due to (d	or as a conseq	Fail quence of):	lure :	n in Pert I.		id tobacco uae		
	resulting In death	nts i) Lest	c	Due to (d	or as a conseq	Fail quence of):	lure :	n in Pert I.	1 (24a. W		0 3 ☐ Prob	
riigalciail/medical	resulting In death	nts i) Lest	c	Due to (d	or as a conseq	Fail quence of):	lure :	n in Pert I.	24a. W	Yee 2 N	24b. We	ably 4 U
e Completed by Physician/Medical Examiner	Pert ii. Other eign	ns) Lest hificent conditions	c	Due to (d	or as a conseq	Fail quence of):	lure :		24a. W. pe	as en autopsy rformed?	24b. We	re autopsy finiteble prior to npletion of cardeeth?
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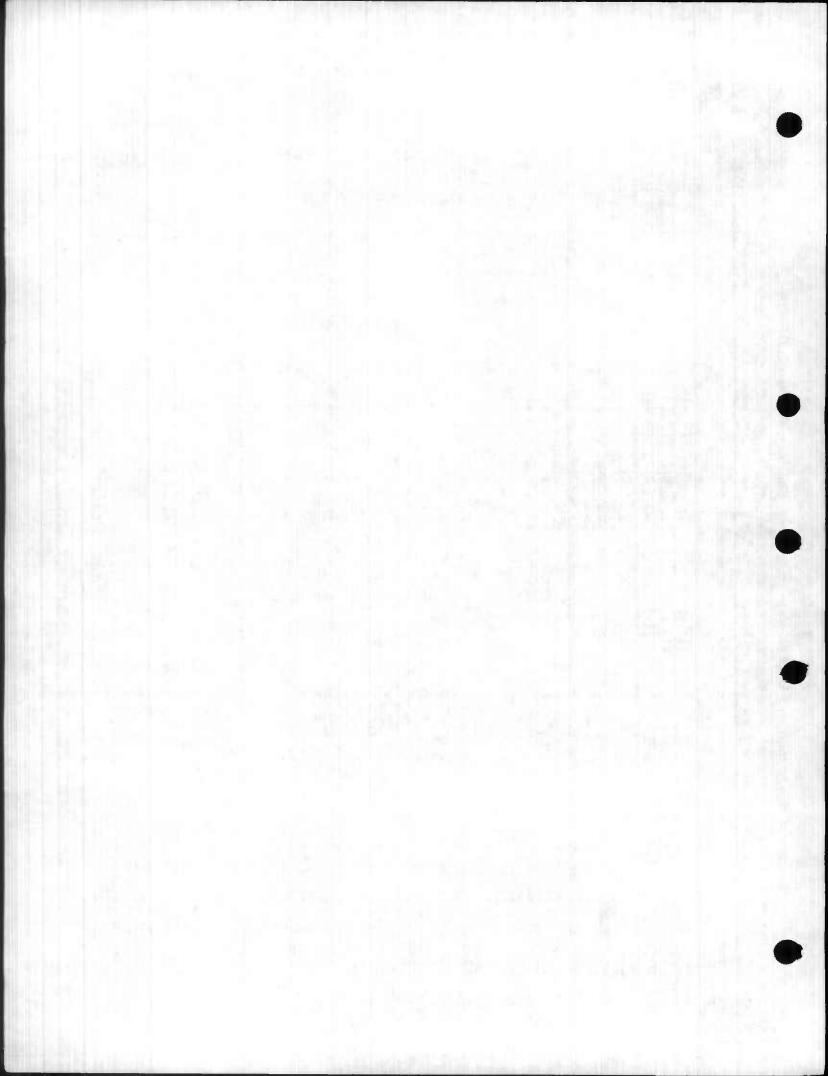
		Decedent's Name (First, Middle, L	ast)		C	ertifica	ite of	Death	2. Dete of Dee	eg. No.		3. Time of Deeth
Physic /Medi		JOSEPH	I E. Z	OLLI	CKOFF	ER			December	Dev) Year	10:10 P
Exami		4a. Fecility Name (If not institution, g. Alice Byrd Tawes						4b. City, Town, or Crisfi		4c. County	of Deeth	set.
Funeral Director		-		Age (In yrs.	last birthda Yrs.	y) If Unc	er 1 Year s Deys		8. Dete of Birth	Yeer) 1926	9. Birthple	aca (Stete or Forei
show		Usuel Residence of Decedent 10a. Stete 10b. County		10c. Cit	ty, Town or							d. Inside City Limit
the Mer 28a-f st	ector	Maryland Somers	set				sfiel	.d		0g. Citizen of \	Mhat Count	1 ☐ Yes 2X N
ath with	Funeral Director	3923 Hinman Lane	e			10	2181	7			S.A.	.,,
5-0020 72 hours efter death with the Meryland natural; or items 23a or 28a-f show dical Examinat must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	12. Wes Decede Armed Force 1 XYes 2 If Yes, Give Year or Date	s? □No Wor	,s. 13 1d II		edent of lecify Cub	dispenic Origin? (Sen, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)		e - America k, White, e	
21215-0020 d within 72 hours of giene. In than "natural", or the wedical Exam.	Completed	15. Decadent's I (Specify only highest g Elementery/Secondery (0-12)	Education rede completed) College (1-4	or 5+)		edent's Usive kind of NOT	ual Occup vork done use retire	petion during most of word d)		16b. Kind of B		ustry Ifacturin
be filed vital Hygie d other it	Be Co	8 17. Fether's Name (First, Middle, Les	t)		WC1	uer		18. Mother's Ner	me (First, Middle, i			ractur in
- 0 2 0 o	ToE	William Zollicko			1				Milroy			
E E N h		19a. Informent's Name/Relationship William T. Zollickof		ephew)				end Number or Ru venue –				
S = 2		20a. Method of Disposition 1X Burial 2 Cremetion 3 4 Donetion 5 Other (Spec		to	Plece of Dis cometery, co W Memo	position (A rematory o	eme of other pla	ca)		20c. Location -	City or Tov	vn, Stete
Baltim permit. Pa Depertmen important: eny injury once.		21. Signeture of Fureral Service Lice Robert H. Bi	Buch	lay	<	Brade	shaw	& Sons Fin St. –			21817	
trificate be executed trificate be executed by physician end es the buriel-transit	edicai Examiner	disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	6. Met.	Due to (d	or es e cons	equence o	f): f):	Carcino	ma			
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	Be Co	25. Wes case referred to medical						26. Plece of De	ath (Check only or	es 2 12 No	1	lYes 2□ No
of Vita Physician: this certific	2	exeminer? 1 Yes 2 No 27. Menner of Deeth	Hospitel: 1 Inp		ER/Outpet		JUA		lome 5 ☐ Resid)
T ge age	Certification:	1 Maturel 5 Pending 2 Accident investigetic 3 Suicide 6 Could not	on	njury Dey Year)	28b. Time Injury		28c. Inju Wo 1 [ry et rk? Yes 2 □ No	28d. Describe h			
Divisio To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the t	Certifi	4 Homicide determine	289. Place of	Injury - At he etc. (Specif	ome, ferm, :	street, fect	ory, office		28f. Location (S City or Tow	treet end Numl n, State)	er or Rural	Route Number,
Hosp 124 hou e Fune vietely fi	edical	29a. Certifier (Check only one) 1 **Certifying P 2 **Medical Example 1 Medical Example	hyeiclen: To the be miner: On the besis end manner	s of examina	wledge, deation end/or	ath occurre Investigeti	d et the ti on, in my d	me, date end plece opinion, deeth occu	e, end due to the curred et the time, d	euse(s) end me lete end placa,	enner es ste end due to	eted. the cause(s)
To th To th comp	M	29b. Signature and title of cartifier				2		se number	2	9d. Dete signe		
		30. Name end eddress of person who	completed cause of	of deeth (Item	7 n 23e) (Typ	e, Print)	D 48	U98		Dec. 1	o, 20	00
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	1	vijaj naramour	COLICITA LIGHT	J Z	CUI Hd	TT III	.qiiwa	y - Cris	riera, M	2181	/	



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State of Maryland / Department of Health and Mental Hygiene 00 42261

		Certificate of Death Reg. No.	
-	Physician /Medical	1. Decedent's Name (First, Middle, Last) ANHONY 2. Date of Death Month Day Year 1845	m
	Examiner	4a. Facility Nama (If Not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Funeral Director	BON SECOURS HOSPITAL 5. Social Security Number 212-60-5078 BALTIMORE F. Age (in yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. Aug 16, 1951 9. Birthplace (State or Foreign Unit) Wink Aug 16, 1951	gn
	T	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit	ts
	Mary Mary Mad a	MD D-14d	
	th with the Maryli 23e or 28e-f sho ust be notified at nal Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	her death v r heme 23s siner must	2202 Penrose Avenue 21223 USA 11. Marital Status 12. Was Decedent Evar in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
020	art, or han Examiner	MV Other Was OVIAID Consider	
21215-0020	ed within 72 ht yglens. yglens. rt, the Medical Commisted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unik 16a. Decedent's Usuat Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Unik 16b. Kind of Business/Industry Unik	
and 2	E SOUTH B	17. Fathar's Nama (First, Middla, Last) UNK 18. Mother's Nama (First, Middla, Maiden Sumame) UNK	
W	nd 2 should iffn and Man 27 is merke r traumetic	19a. Informant's Name/Relationship (Type, Print) UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) UNK	
imore,	Pages 1 a nant of Her ant: If them ury or othe	20a. Method of Disposition 1	
Balt	Depart Depart Import any log	21. Signature of Funaral Sarvice Licensea Royald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201	
40.		23a. Part. Enter the disease, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death	
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure / WK	,
	P # 5	Due to (or as a consequence of): WK	
30,	ficate be assecuted physician and is the bunal-transit		-
68760,	5 0 6	resulting in death) Last	15
O. B.	at the death certil d by the attending etached for use a	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	th?
ls, P.O.	es that the igned by be detacted by Phy	s made the state of the state o	
ecord	The law requir sate has been s page 2 should Completed	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?	5
E E	certificate has rector, page 2		
Z Z	Physician: this certific ral director,	25. Was case referred to medical axaminer? 1 Yes 2D No	
	Attending Physics results and actor. After this of by the funeral direction: To		
Divis	2 # SE	3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Could not be determined 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State)	
	To the Hospital within 24 hours a vithin 24 hours completely filled completely filled Medical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 21 Mad cat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the comple	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)	
		30. Name and address of person who completed cause of death (iterfu23a) (Type, Print)	
		Insuceling De Allow every W 516 N. Rolling Rel Birto 2002	2
	State Registrar		



Physician

Pieas	State of M	Maryland / D		nt of H	lealth a		Mental Hyg	iene (2262
Decedent's Nama (First, Middla,	(ect)		Jerunoan	601	Deam		2. Data of Deat	eg. No.		3. Tima of Death
Emily Marie							DECEMBE	Day	2000	6:39 A.M
4e Facility Neme (II not institution, FRANKLIN SQUAR			0		4b. City, Tov		cocation of Death	-	ALTIM	ORE
		Age (In yrs. last birth	- 7 - 60 - 50	Deys	If Under 2 Hours	24 Hrs. Min.	8. Data of Birth (Month, Day, Feb. 9.	, Year)	9. Birthpla Country Maryl	
Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City, Town	er Legation				1, 000			
Maryland Baltin	nore		Baltimor							d. Inside City Limits 1 ☐ Yes 2 💢 No
10e. Street and Number 55 Chesthill Co	ourt		10f. Zip			212.	36		1.S.A.	
11. Marital Status 1. Never Marriad 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces of 1 Yas 2 If Yas, Giva Year or Dates:	?] No	13. Was Deced		dispanic Orig an, Mexican Specify:		pecify Yes or No- p Rican, atc.)	14. Rad Bla Specif	ack, White, at	tc.
15. Decedent's (Specify only highast	Education grada complated)	16a. f	Decedent's Usua (Giva kind of wor lifa. DO NOT us	al Occup ork dona	ation during most	t of work	king	16b. Kind of B	Jusiness/Indu	istry
Elementery/Secondary (0-12) 2nd Grade	Collega (1-4or	r 5+)	Tifa. DO NOT US Dependen		Stude	ent		Elemen		chool
17. Fether's Nema (First, Middle, La Carmine J. Av	uena	Trail is					ne (First, Middle, M arie Bi			
19a. Informant's Name/Ralationshi							ral Routa Number		, Stata, Zip (Code)
Mr. Carmine J. 20e. Mathod of Disposition		20b. Place of I	5 Chesth Disposition (Namy, crematory or o	ma of		Bal	timore,	MD 21 20c. Location		m, Steta
1 X Buriel 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe						2	1/2/01	Baltim	ore. M	aryland
21. Signatura of Funaral Sarvica Li	complications that cause only one causa on each l	line.	ot enter tha mod	nunek Bela da of dyin	r Fune air Rd	cardiac		est,		Approximeta Intervel Between Onset and Death
Immediata Causa (Final disaasa or condition rasulting in death)	COMPLIC	CATTONS O	OF PAN onsequence of):	IHYF AN	D A	LIT	-ARISM RDI SYI	NDROM	IE !	
Sequantially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disaase or injury	D	Due to (or es e co	onsequance of):						-	
thet initieted events rasulting in death) Last	d	Due to (or as a co	insequence of):						t	
Part II. Other significant condition	ns contributing to death	but not rasulting in	tha undartying	causa gi	van in Part I		23b. Did to	obacco use co	ontribute to	the cause of death
							1 🗆 Yı	es ZENo	3 Prob	ably 4 Unknow
							24a. Was a perform		avai	ra autopsy findings ilable prior to appletion of cause eath?
							1□Ya	as 200 No	10	Yes 2□ No
25. Was casa refarred to medical examinar?	Hospital:	74		Oth Oth	her _		ith (Check only on			
1⊠Yes 2 No 27. Mannar of Death	1 Li Inpati			UA	4 LI NU	7	oma 5 Raside)
1 Natural 5 Panding 2 Accident investiga 3 Suicide 6 Could no	ation ot he		М		rk?]Yas 2∐I					
4 Homicide determin	ned 28a. Place of In	njury - At homa, farr atc. <i>(Specify)</i>	m, street, factory	y, office			28f. Location (St City or Town		ber or Rurai	Routa Number,
29a. Certifiar (Check only one)	Physician: To the best examiner: On the basis of and manner st	of examination and	deeth occurred For Invastigetion	et tha tin	ne, date and opinion, dae	d pleca, ith occur	end due to the carred at the time, d	ause(s) end male end place	nannar as sta , and due to	ited. the cause(s)
29b. Signatura and title of certifier	7				se number		2	29d. Date sign	ed (Month, D	lay, Year)
15 10			7	NAMI	51669	8		DEDEM	REP ,	29 2000

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vitai Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

/Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylau Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or here 23a or 28e-f ahow any injury or other traumatic event, the Medical Examiner must be notified at prose.

Physician /Medical Examiner

AVENA, EMILY MARIE

To Be Completed by Funeral Director

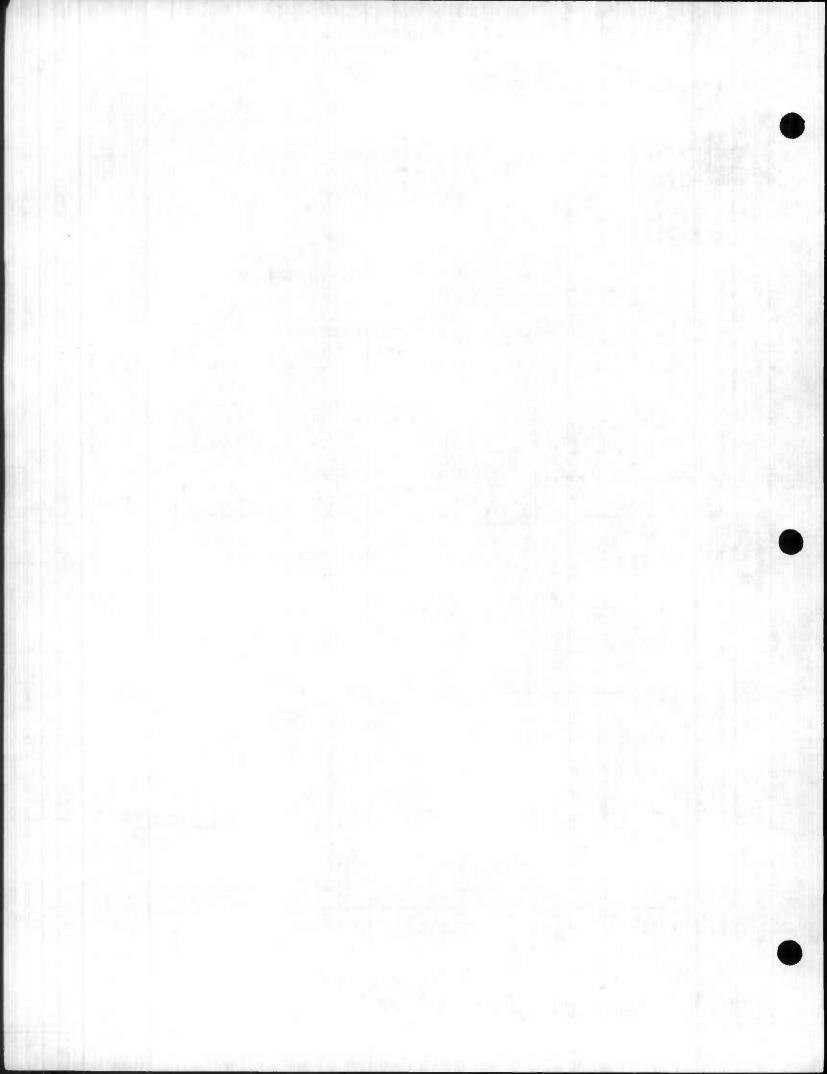
10 State Registrar

31. Data filed (Month, Day, Year) JAN 0 4 2001

32. Region s Signatur

30. Nama and eddrass of person who complated causa of death (flam 23a) (Type, Print)

DAVID SOERGEL, MD., 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD

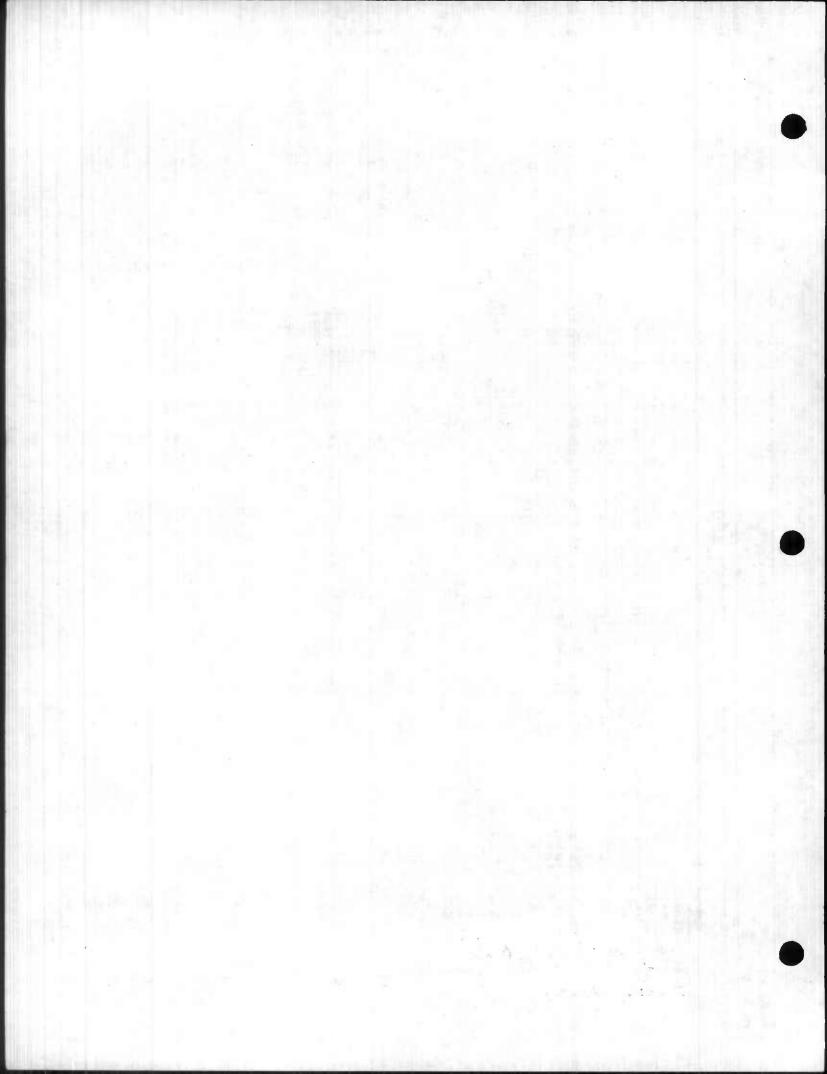


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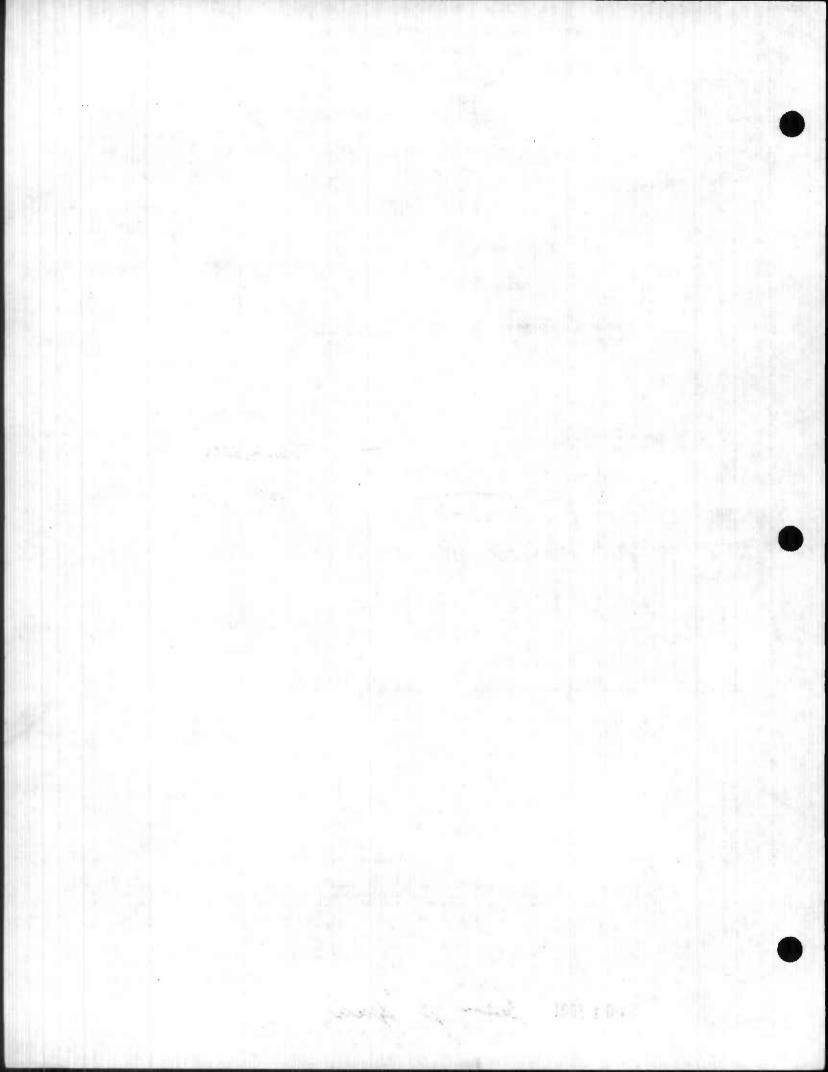
RONALD ADAMS		State of Mai	ryland / Depa <i>Cel</i>	artment tificate				giene () () Reg. No.	422	63
Physician /Medical Examiner	Decedent's Name (First, Middle, Last Ronald Wiley Adam Facility Name (If not Institution, give	ıs			4b.	City, Town, or Lo	2. Date of Dec Month DECEMBI	Day ER 28,20 4c. County	Year 000 10	:36P.M.
Funeral Director	214 44 0000		(In yrs. last birthday) Yrs.	If Under 1 Months		ALTIMORE If Under 24 Hrs. Hours Min.	8. Dete of Bird Month, Da May 1,	N/A 1947	9. Birthplace (S Country) Mary Lan	State or Foreign
The Maryland 28s-f show notified at rector	Usual Residence of Decedent 10a. State 10b. County MD N/A		10c. City, Town or Lo Baltimo							ide City Limits
6 5 G	10a. Street and Number 1726 St. Paul St		ovio II C	10f. Zip C)2	and Orlain? (San			What Country? States te - American Ind	0.0
036 our after death v al, or tems 23s Exemple ment by Funeral	11. Merital Status 1 Never Married 2 Merrled 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		Yes, specify	7.	panic Origin? (Sp Mexican, Puerto Specify:	Rican, etc.)	Bla	ck, White, etc. V: Black	eri,
Ind 21215-0036 be filed within 72 hours at all hygiene d other than "natural", or event, the Medical Exam Be Completed by 8	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+	(Give	dent's Usual (kind of work DO NOT use tenanc	done dui retired)	on ring most of work	ing		usiness/Industry	Z
Maryland 2 of 2 should be filed of 2 should be filed of 7 is marked other traumatic event, at To Be Co	17. Father's Name (First, Middle, Last) Walter Alexander	Adams	Hall	terrario	7	8. Mother's Name Roxie W				
C 25 CK FF	19a. Informant's Name/Relationship (7) Barbara Adams / s 20e. Method of Disposition			Silve	er Cr	ceek Rd.		sville,		8
altimore, mit. Pages 1 a partment of Hes contants if then rinjury or oths	1 X Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify, 21. Signeture of Funeral Service Licens		Mt. Aubum	natory or oth	y, Ir	r.	1/4/01		ore, MD	410
Physician /Medical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the cause on each line		er the mode	of dying,	n Pastur such es cardiac	or respiratory e	rrest,	Appro Interv Onse	286 eximate al Between t and Death
death certificate be assouted eathending physician and of or use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or as a consecue to (or as a consecue							
S, P.O. as that the de gned by the to be detached by Physic	Part II. Other significant conditions co	ntributing to death but	nof resulting in the u	nderlying cau	use given	in Part I.			ontribute to the c	ause of death?
Record ne lew require s has been si ge 2 should ompleted							perfo	an autopsy ormed? ECTION Yes 2X No	of death?	prior to
on of Vita ding Physicien: h. After this certific funeral director tion: To Be	27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)			Other c. Injury a Work?	4 U Nursing Ho	ome 5 ☐ Resi 28d. Describe	dence 6 DOti how injury occu	rred	CENE
2 5 2 9 O	4 Homicide determined	building, etc.	my knowledge, deat	n occurred at	the time		City or To	wn, State) cause(s) and m		
To the Hospi within 24 hou To the Funer completely fil	29b. Signatury and title of certifier	iner: On the basis of e	ed.	29c. 1	License i			29d. Date signe	ed (Month, Day,)	(ear)
State	30. Name and address of person who con J. Laron Locks M. E. 31. Date filed (Month, Day, Year)	ompleted cause of dec			nn S	street, E	Baltimo	re, Mary	yland 21	201

DHMH 16 Rev 6/95

ORIGINAL.



RT			per me G		ı yr	Ce	rtificate	of	Death		Reg. No.	J ly	2264
Physician	1	anthony	First, Middle, L	.ast)	Albert					2. Date of D Month DECEM	Dey	Year	3. Time of Death 9:19A.M.
Medical/ Examiner	An Er	cility Name (If n	ot Institution, g	ive street and nu	mber)				4b. City, Town, or I				
uneral		HADY GRO		ENTIST H		L.s. last birthday)	If Under 1	Year	ROCKVILI If Under 24 Hrs. Hours Min.		MONTG		aca (State or Fore
ctor		2-42-8663		1 X M 2□ F	-78 -	48 Yrs.	WOMIS	Jayo	Tiodis Mill.	March		Count	PA
Director	10a. S	Residence of D State 1 MD	0b. County	gamery	10c. (City, Town or Lo	ocation hersburg	g				10	od. Inside City Limi
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by Funeral		arital Status Never Married Widowed 4		Armed Fo	2 □ No U	nk.	Was Deceder If Yes, specify	/ Cuba	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No Rican, etc.)		ce - America ck, White, e	
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To Be	C	harles A	lbert							Sophie			
	Ma	nformant's Nam	usso /	(Type, Print) Sister	l-au	32	235 Shelt	tan	Avenue B	ethlehem	PA 1802	20	
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8500	21. 8	ignature of Fune	erel Service Lic	ansee Victo	r P. Doo		Charles	L.	Stevens Fu	neral Ho	me, Inc.		
	23a	Part1. Enter the	disease, or co	mplications that	caused the de					, Baltim	ore Maryla		Approximate
6	Imme disea resul	Part1. Enter the shock, or heart dediate Cause (Fi se or condition ting in death)			OSCLEROI		OVASCULA	of dyir	ng, such as cardia	, Baltim			
Examiner	Immedisea resul	ediate Cause (Fi	nal litions, tediate ring jury		OSCLEROT Due to	ath. Do not en	OVASCULA oquence of):	of dyir	ng, such as cardia	, Baltim			Approximate tnterval Between
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botor, page 2 should be detached for use as the buriel-transit of posts and	Sequition of the sequit	ediate Cause (Fi ise or condition ting in death) entially list cond , leeding to imm e. Enter Underly e (Disease or in nitiated events ting in death) La	itilons, lediate jury st	a. ATHER	Due to	ath. Do not en	OVASCULA equence of): equence of): equence of):	of dyir	TSFASE ven in Part I.	23b. Di 24a. We	d tobacco use co Yes 2 No as an autopsy rformed?	ontribute to 3 Prob	Approximate toterval Between Onset and Death Onset on Death
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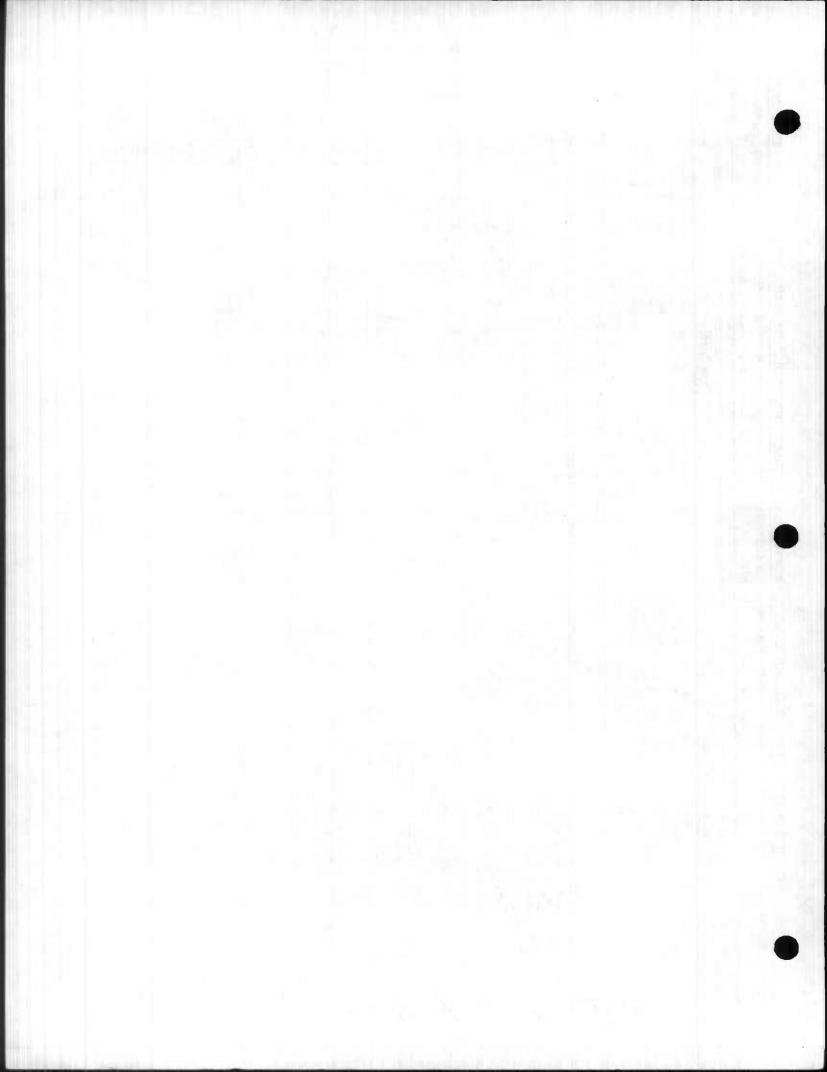


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Rea. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** RU 1125 PM DECEMBER 30 2000 /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTHWEST BALTIMORE RAN DALLSTOUN HOSP(TAL CEMBR Inder 1 Year If Under 24 Hrs. If Unde Birthplaca (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Aga (In yrs. last birthday) **Funeral** Days Months 1 M 2 XF Yrs. 90 July 8,1910 Director 213-12-8158 Maryland Usual Rasidence of Decedant deeth with the Meryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yas 2 No Directo Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2032 N. Rolling Road 21244 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |teme 14. Race - American Indian, Black, Whita, atc. 12. Was Decedant Evar in U.S. Armed Forcas? 11 Marital Status Pages 1 and 2 should be filed within 72 hours effer nent of Health and Mental Hygiene. int: If Item 27 is merked other than "natural", or Ite 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Bookkeeper Real Estate item 27 is marked other other traumatic event. Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Henry Kruhm Mae (unknown) 19a. tnformant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Lauer/ Daughter 2032 N. Rolling Road, Woodlawn, Maryland 21244 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from Stata 6 permit. Pege Depertment of Important: If any Injury or Bayview Crematory 1-2-2001 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funaral Savice License 22. Nama and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert tellure. List only one ceuse on each line. Approximata Intarval Between Onset end Death **Physician** /Medical Immediata Causa (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disaasa or condition resulting in deeth) Examiner Examiner The lew requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disease or Injury that initiated evants rasulting in daath) Last Due to (or as a consequence of): pue Box 68760. Physician/Medical Dua to (or as a consequence of): USB signed by the atte Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Unknown 1 Yes 2 No 3 Probably þ 24a. Wes an autopsy performed? page 2 should Be Completed 24b. Were eutopsy tindings available prior to completion of cause of death? certificate or Attending Physician: funerel director. 25. Was casa ratarred to medical axaminar? 26. Place of Deeth (Check only one) axaminar?
1 Yas 2 No

27. Mannar of Death
1 Natural 5 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3□ DOA this 28a. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 26b. Time of 28c. Injury at Work? After 5 Panding 1 Yes 2 No within 24 hours after deeth. To the Funeral Director: A invastigation 2 Accidant 6 Could not be datarmined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, tarm, street, factory, office building, etc. (Specify) filled in by 4 Homicida Hospital Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifian completely (Check only one) the 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifian 29c. License number ELEMBER 30, 2000 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) COURT ROAD 540 32. Registrar's Signal State Registra



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#18,19b,20b,20c perFHG791 1/10/01 EW Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dey 22 2000 **Physician** ESTELLE BELLE 1:00 pm December /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner BATimore TOSPITA O BALTMORE
If Under 24 Hrs. | 8. Dete of Birth SINAI If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Mar 12, 19 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Deys 1□ M 2\ F 240-34-9672 Yrs. North Carolina 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore tX Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4669 Falls Road 21209 14. Raca - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: black þ 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 0 domestic private 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Charles Murphy Alzora(Unknown) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Geraldine Johnson/daughter 1421 McCulloh ST Baltimore, Maryland 21217 20b. Place of Disposition (Neme of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 □ Donetion 5 🖔 Other (Specify) in state Arbutus Memorial Gardens 1/11/01 Arbutus, Md 21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

State Anatomy Board 655 W.

Baltimore, MD 21201

23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. 655 W. Baltimore Street Interval Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in deeth) pertension Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Preumonia 1 Yes 2 No 3 Probably 4 Onknown Aspiration 24b. Were eutopsy findings evailable prior to completion of cause of death? Insufficiency 1 Yes 2 No 1 Yes 22 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menner of Death 28b. Time of 28d. Describe how injury occurred

Examiner The lew requires that the death certificate be asscuted Box 68760, P.0. of Vital Records, or Attending Physician: Division after death.

Be Completed by Physician/Medical Examiner edical Certification: To

Funeral

Director

Hygiene. other than "natural", or flams 23a or 28a-f ehow

filed within 72 hours efter deeth

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permit. Pages 1 and 2 s Department of Heelth er important: if item 27 la eny injury or other trau

Physician

/Medical

28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier

29b. Signeture and title of contified

29c. License number 29d. Dete signed (Month, Day, Year)

30 Neme and andress of perso ho completed cause of deeth (Item 23a) (Type, Print) DERI

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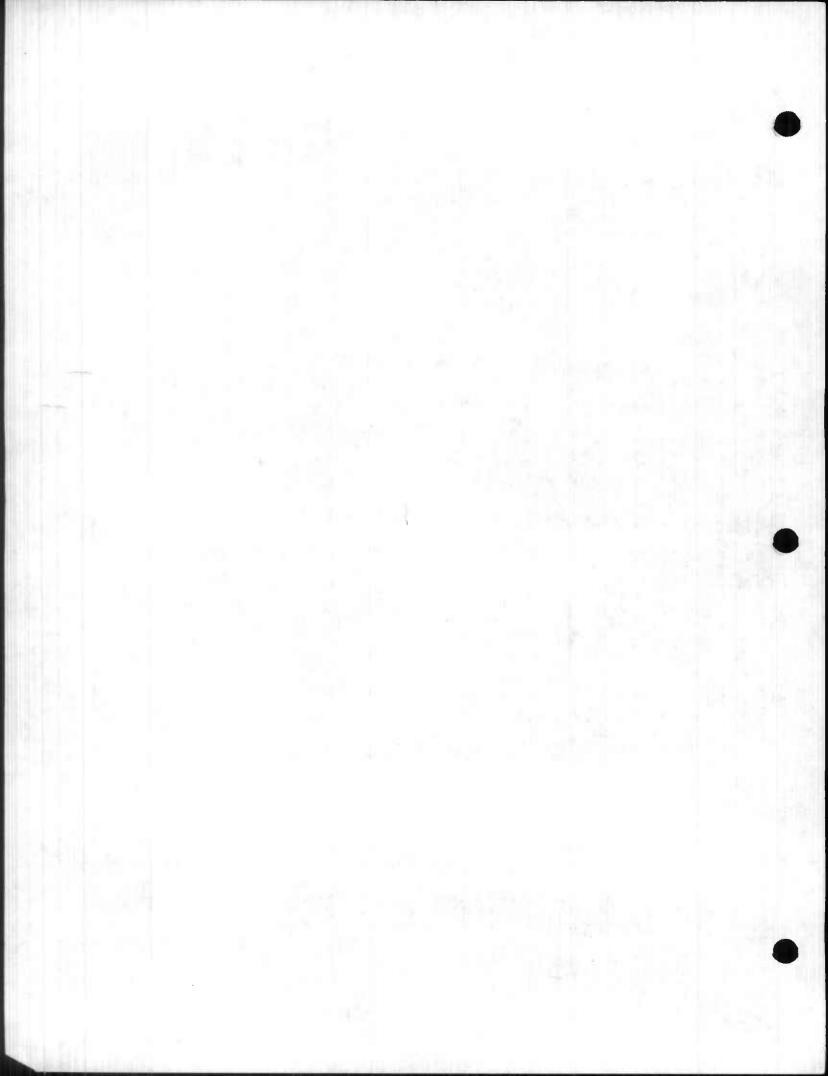
State Registrar 31. Dete filed (Month, Day, Year) JAN 0 4 2001

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BURKE 32. Registrer's Signature inera

To the Hospital e within 24 hours a To the Funeral D

completely



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death harlotte Buston **Physician** 12:35 pm December 18,2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street and number, **Examiner** HUnder 1 Yeer | HUnder 24 Hrs. | 8 Date of S 405pit 7. Age (Ih yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 9. Birthplece (Stete or 5. Social Security Number 6. Sex **Funeral** 1 M 2 F 46-370 212 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Catonsv! Directo Maylard 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code USA Funeral 12. Wes Decedent Eyer in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 Yes 2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nentary/Secondary (0-,12) College (1-4or 5+) Housewi h (rade 18. Mother's Name (First, Middle, Maiden Suman 17. Father's Name (First, Middle, Last) Mans exanger 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland (0002/danahTer Sute 20b. Place of Disposition (Name of 20c. Location - City or Town, Stale 20a. Method of Disposition Date 1 Burlel 2 □ Cremetion 3 Removel from State Marylan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 2deric Approximete Intervel Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. **Physician** /Medical fmmediate Cause (Final disease or condition resulting in deeth) **Examiner** Physician/Medicai Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Box 68760. Due to (or es e consequence of): P.O. Part ft. Other significant conditions contributing to death but met resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 5 Division of Vital Records. Be Completed by 24a. Wes an autopsy 24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ MG or Attending Physician: 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 → No 1. Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending after death. Director: Af 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) To the Hospital of within 24 hours are To the Funeral Ecompletaly filled Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner steted. 29a. Certifier 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier D31344 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

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Registrar

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32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12:35 BAZEMORE NEHEMIAH DEC 21 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** BALTIMORE CITY BALTIMORE AGNES HEALTH CARE If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Months Days 38-28-038 Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Maryand Directo 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 3535 212 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 WNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married "natural", or 1 Yes 2 No Specify. by 3 DWidowed 4 □ Divorced Hygiene. Wher than "natura ent, the Medical.] Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filled within Elementary/Secondery (0-42) College (1-4or 5+) INCMOS Genera (Trag marked other 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) 89 should be Mental RNSOM 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Narhe/Relationship (Type, Print) Pages 1 and 2 s mant of Health ar ä 604 Ballimor Health Hem 27 I illa age ane KY-dama here 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State butus 4 ☐ Donation 5 ☐ Other (Specify) lar 21. Signeture of Funeral Servica Licenses 22. Name and Address of Facility IMON ND 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical SEPTIC WEEK Examiner EHEMIAH BAZEMORE Due to (or as a consequenca of): Examiner STAPHYLOCOCCAL BACTEREMIA ENTEROLOCCAL attending physicien and for use as the burial-trensit death certificate be asscuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? of Vital Records, P.O. been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL DISETSE p 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an autopsy DISORDER SEIZURE certificete hes t irector, page 2 s page 2000 1 Tyes 1 Yes 2 No CEREBROVASCULAR ACCIDENT Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: NAME Division or Attending 5 Pending investigation 1. Natural 1 Yes 2 No death. erel Director: A filled in by the f 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 6 Could nof be Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end fitte of certifier

Registrar

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BALTIMORE,

Mro.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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31. Dete filed (Month, Dey, Year)

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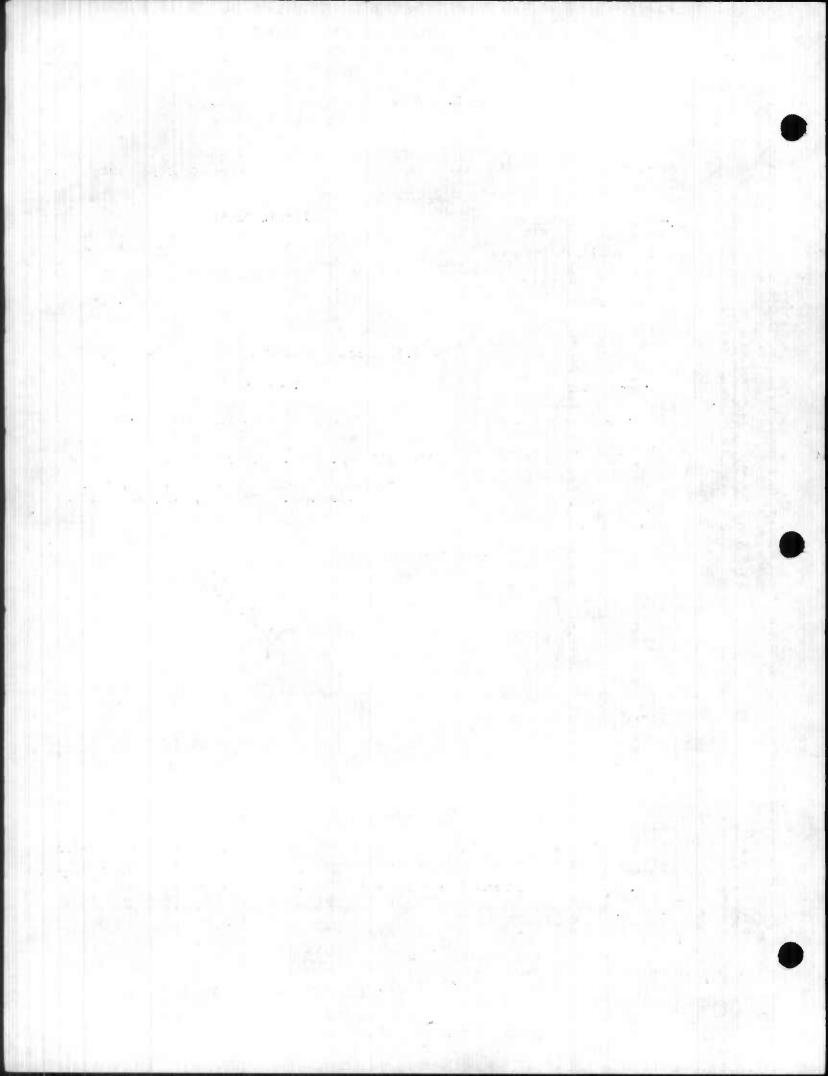
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DECEMBER 21, 2000

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State of Maryland / Department of Health and Mental Hygiene 1, 2260

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Physician	Decedent's Nama (First, Middle,		L. Broo	oks			2. Date of Dea Month Decembe	Day	Year 2000	3. Tima of Death 12:36 P.
/Medical Examiner	4a Fecility Nama (If not institution, Johns Hopkins Be		cal Cen	ter	41	Baltimo	Location of Death	4c. County		12:30 P.
Funeral Director	5. Social Security Number 236-24-7994	Sex 7. Ag	e (In yrs. last bir 76	thday) If Und Yrs. Month	der 1 Year Is Days	If Undar 24 Hrs Hours Min.		Year) 1,1924	9. Birthple Count West	ace (State or Fore ry) Virginia
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r Items 23s or 28s-1 showners to the contract of the contract	10e. Street and Number 239 Endsleigh	Avenue		10f. i	Zip Coda	21220	1	Og. Citizen of V United		•
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h and Men Is marke traumatic	19a. Informent's Neme/Reletionship			. Mailing Addra		nd Number or R	ural Routa Number			Code)
Department of Health and Mentel Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, tha Modes. To Be Compi	20a. Mathod of Disposition 1 🖾 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	□ Removel from Stata	20b. Plece o cemata	Disposition (*)	vama of or other plece)		20c. Location -	City or Tov	
Department of H Important: If he any injury or of pncs.	21. Signature of Funaral Sarvice Li		4	22. Name Duda-	and Addras	ol Facility Funeral	Home of	Dundal	k, Ind	
e attending physicien end addresses the buriel-transit and sich and sich and sichan/Medical Examiner	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last	G	Due to (or as a Due to (or as a Due to (or as a	consequence o	of):	di	N. 18	A STATE OF THE STA		
e attending ad for use a	Part II. Other significant condition	contributing to death be	ut not resulting i	n the undarlyin	g causa giva	n in Part I.	23b. Dld to	obacco usa co	ntribute to	the cause of dear
be by	Hypertension						1 N	res 2□ No	24b. We	ebly (X) Unknown
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nis certificate il director, pag To Be Co	25. Was case referred to medical examinar? 1)(C) Yas 2 \(\sum \) No	Hospital: Inpatie	ont 2□ER/Ou	utpatient 3	DOA Otha	r.	ath (Check only on		nar (Specify	·)
ector: Afte by the fund tiffication	27. Mannar of Death 1 Netural 5 Pending 22 Accident 6 Could no 4 Homicida	28a. Data of Inju (Month, De 12-23-20 to be ed 28a. Place of Inju building, etc.	y Year) 28b. 3: 000 3: ury - At homa, fac. (Specify)			at ? 'as 2 No	City or Tow	fell do	OWN Stor or Rura	tairs I Route Number, alnut Ave
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10	30. Name end eddrass of person wi				ie. Ba	ltimore	, Marylar	nd 2122	1	
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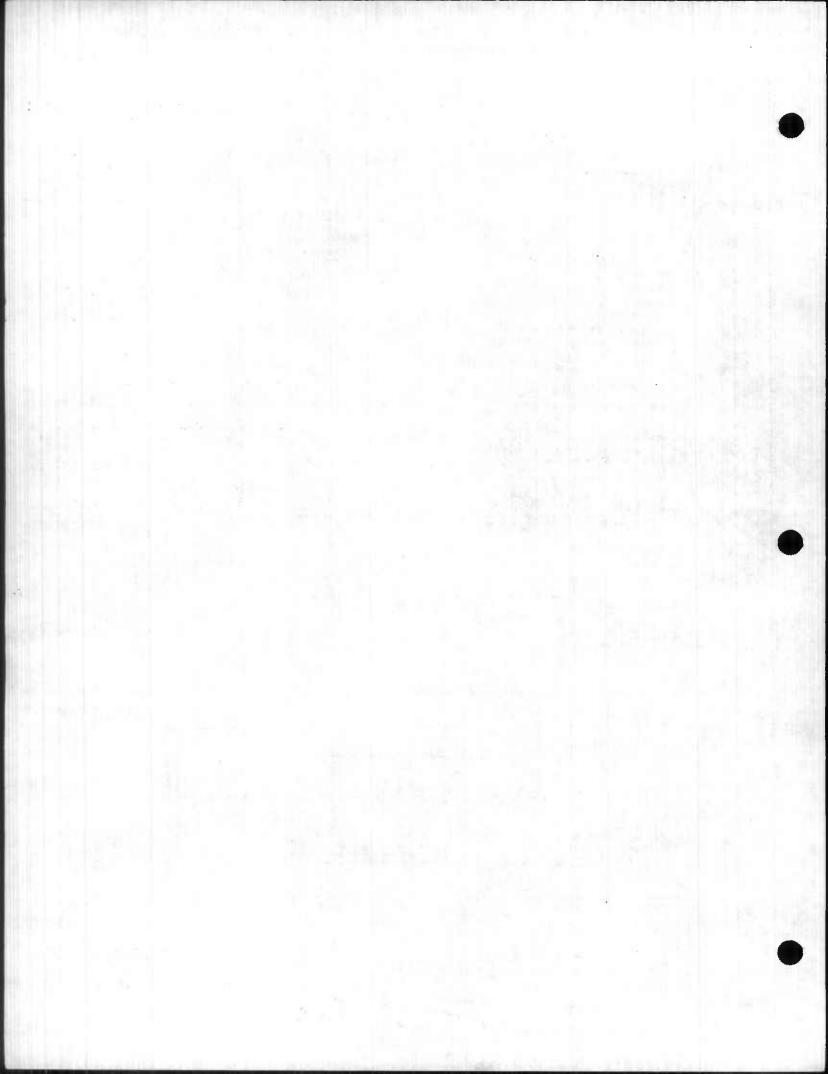
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State of Maryland / Department of Health and Mental Hygiene 1 2271

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	Calun	JB. L	rusad	h.			B. SCRUG PRESTON				. 21213
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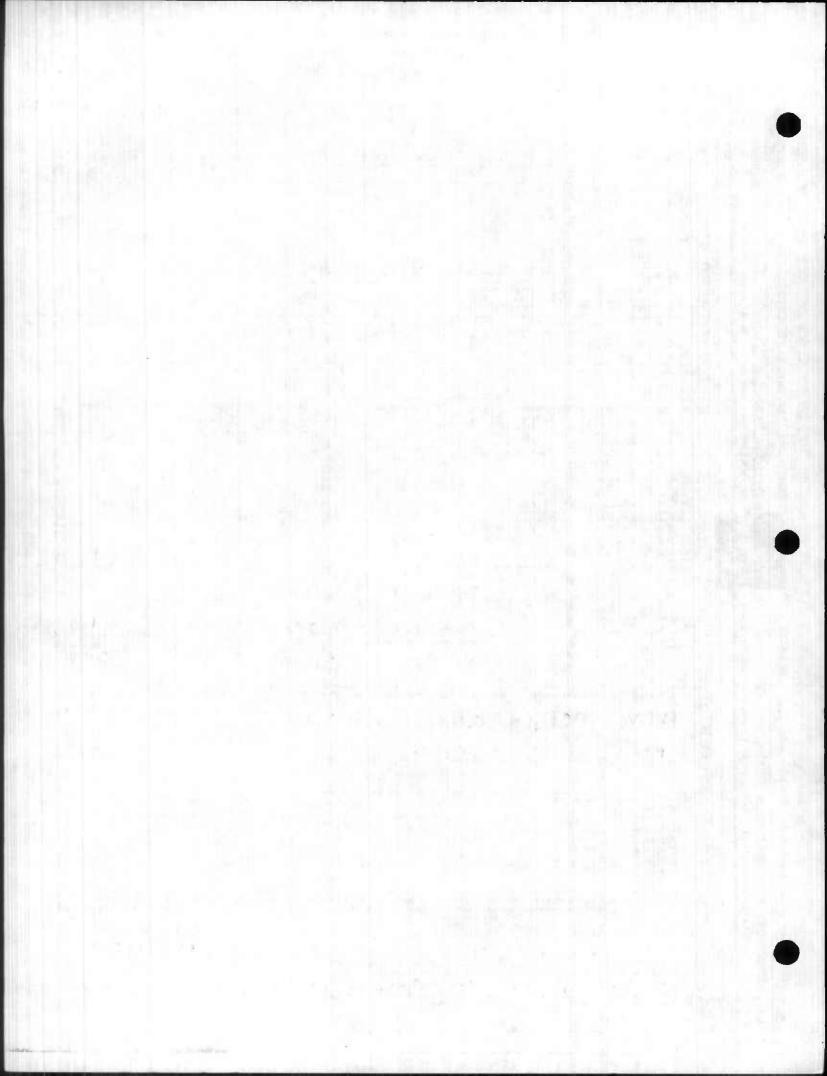
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State of Maryland / Department of Health and Mental Hygiene

				Certifical	e of	Death			Reg. No.		3 5 5 1 1
Physician /Medical		Baker						2. Data of De Month Decem	bel 31	Year 2000	3. Tima of Death
Examiner	4a Facility Nama (If not institution, giv Union Memorial					Balt:		cation of Deat	N/A	y of Death	
Funeral Director	212-07-0013	ax 7. Ag	ga (In yrs. last birth 88 Yı	day) If Unda Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Aug. 12	rth ay, Yaar) 2,1912	Coun	laca (Stata or Fore try) Carolina
Med at	Usuat Rasidance of Decedent 10a. Stete 10b. County Maryland N/A		10c. City, Town							11	0d. Inside City Lim
23a or 28a-f shout be notified at	10e. Street and Number 1812 E. 28th Stre	et			218				10g. Citizan of United		
Examiner mu by Funer	11. Maritel Status 1 □ Nevar Merried 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Armed Forcas' 1 Yas 2 If Yas, Give Yaar or Datas:	?	13. Was Dece If Yas, spe 1 Yas	city Cub	lispanic Ori en, Mexicen Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, atc.)	Bla	ce - Americack, Whita, a	atc.
or than "natural, the Medical	15. Decedent's E (Specify only highast gra Elementary/Secondary (0-12)			Decedent's Usu Give kind of wo life. DO NOT	ork dona se ratire	during mos	t of worki	ing	16b. Kind of E		
Mental Hygie riked other i dic event, th To Be Co	17. Father's Name (First, Middle, Last, Ezekiel Baker			Labore			ars Nama		Bethleh Maidan Sumai		eer
27 is mar to traumal	19a. Informant's Name/Ralationship (Constance King/ D			Mailing Addras 2 E. 2					per, City or Town	n, Stata, Zip 21218	Code)
nent of Her int: If Nem ary or othe	20a. Method of Disposition 12X Buriat 2 Cramation 3 4 Donetion 5 Othar (Specific		20b. Ptace of I cometery, Arbutus				1/	Date /3/01	20c. Location Arbutus		wn, Stata
Departi Importa any Inja anica	21. Signatura of Funaral Sarvice Licer			22 Nama a CAFA S 8717 (tepl teer	nen D. nen Bast	Loh	ırmann			MD 21286
physician and street Examiner	23a. Part1. Entar tha disaasa, or com shock, or heert faiture. List only Immediata Causa (Final disaasa or condition resulting in daath) Sequentially list conditions, if any, taading to immadiata cause. Enter Undarlying Cause (Disaase or Injury that initieted events	a	SEPS Due to (or as a co	onsequance of) TUS onsequanca of)	UI	LER	2			22	Intervel Batween Onset and Death Days Month
N 8	Cause (Disaase or Injury that initireted events rasulting in daath) Last	d	Dua to (or as a co	nsequence of)		and				3	years
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£ 0	1 ☐ Yes 2 No 27. Mannar of Death	28a. Data of Inj	ury 28b. Tir		28c. Inju Wo				how injury occu		<i>Y)</i>
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within 24 hours after death. To the Fureral Director: After thi completely filled in by the funeral Medical Certification: 1		ysician: To the best niner: On the basis of and mannar si	of examination and/								
To the	29b. Signatura and titla of certifiar	it, mg		29	c. Licans	se number	25	59	29d. Data sign	1120	טטט
State	30. Nama and addrass of person who VCU'S VCU's Police Poli	PAT	daath (Item 23a) (T 201, E rer's Signetura	iype, Print)	mi	versi	ty	plan	lay f	celti	o, no 21

DHMH 16 Rev 6/95

Registrar



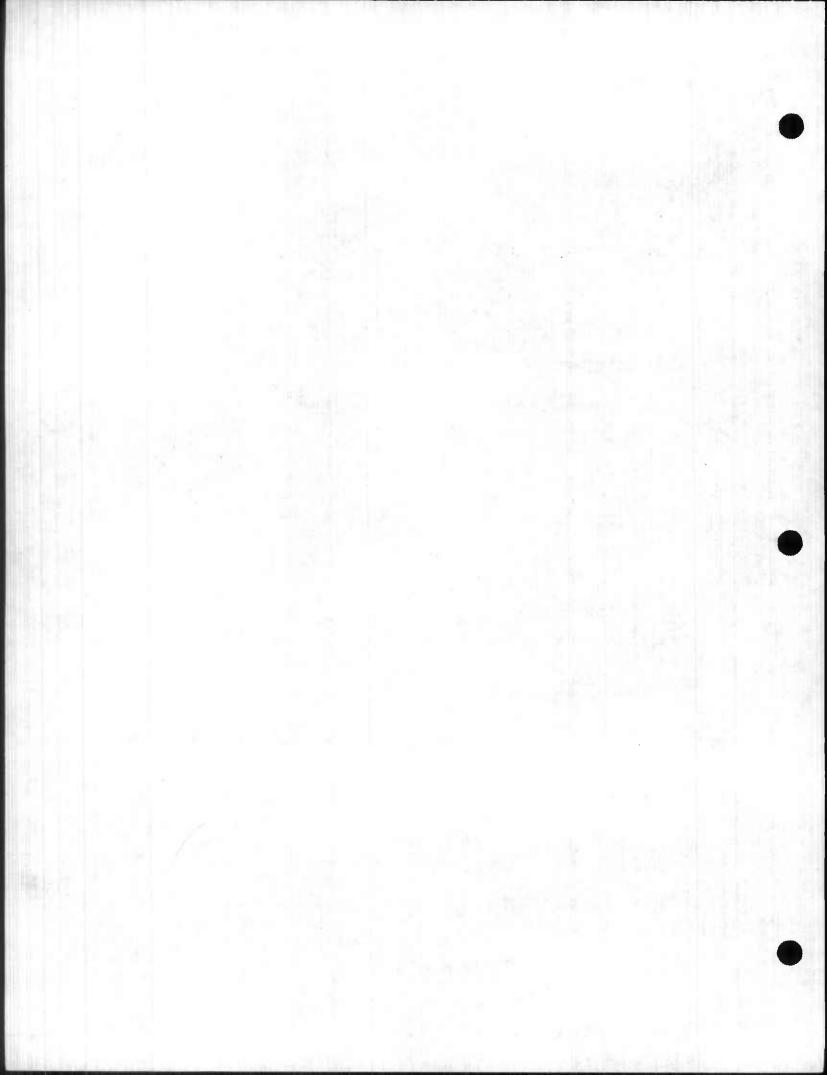
AREM BARAD

DHMH 16 Rev 6/95

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- L	11.	Marital Stetus 1 ☐ Naver Married 2 ☐ Married	12. Wes Decedent Event Armed Forcas?	er in U,S.	if Yes, spe	ecity Cub	en, Mexican, Pue	Specify Yes or No rto Rican, atc.)	Bled	k, White, etc.	naien,
þ		3 ☑ Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:		1 Yas	2D No	Specify:		Specify	: 1	WHITE]
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To Be		SAMUEL		BARAD			CLARA			GOLDE	NBERG
-	19	e. Informant's Neme/Relationship	(Type, Print)			s (Street		Rurel Route Numb	er, City or Town,		
		CARY BARAD / SO	ON				RIFT - CO	DLUMBIA,			
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State of Maryland / Department of Health and Mental Hygiene 0 0 1, 2 2 7 3

					C	ertifica	te of i	Death		Re	g. No.	10-6	6610
	1. Decedent's Nama (First,	Middla, Last,)	J 1 100						2. Deta of Death Month		Year	3. Time of Death
Physician /Medical	JA	CK			E	BALSER				Decembe	Day r 31,2		9:20am
Examiner	4a Facility Name (If not inst	itution, giva	street and nur	nber)			1	lb. City, Town	, or Lo	cation of Death	4c. County	of Death	
	VAMHCS Fort	loward	Divis	ion				Fort Ho	wai	m	Balt	imore	
Funeral	5. Social Security Number			7. Age (In yrs	s. last birthde	y) If Unde	r 1 Year	If Under 24	Hrs	O Date of Right		9. Birthp	lace (Stete or Foreign
Director	212013966	11/2	MM 2LJF	85	Yrs.	WORTS	Days	110013	VIII.	MAR. 27,1	915	0001	MD
	Usual Residence of Decede			1.0									
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tiffe oto	MD N/	A		BA	LTIMOR	RE							
or 28s-f sho be notified at Director	10e. Street and Number					10f. Zi	Code			10	g. Citizen of		ntry?
	6015 BAYWO	OD AVE	NUE					21209			U.S.A		
iner must	11. Merital Status		12. Was Dece Armed For	dent Evar in l	U,S. 1	B. Was Dece If Yes, spe	dent of H	ispanic Origin In, Mexican, F	? (Spe	cify Yes or No- Rican, atc.)		e - Amaric ck, White,	
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X	George Wicks						ort	Howard	, MD	21052			
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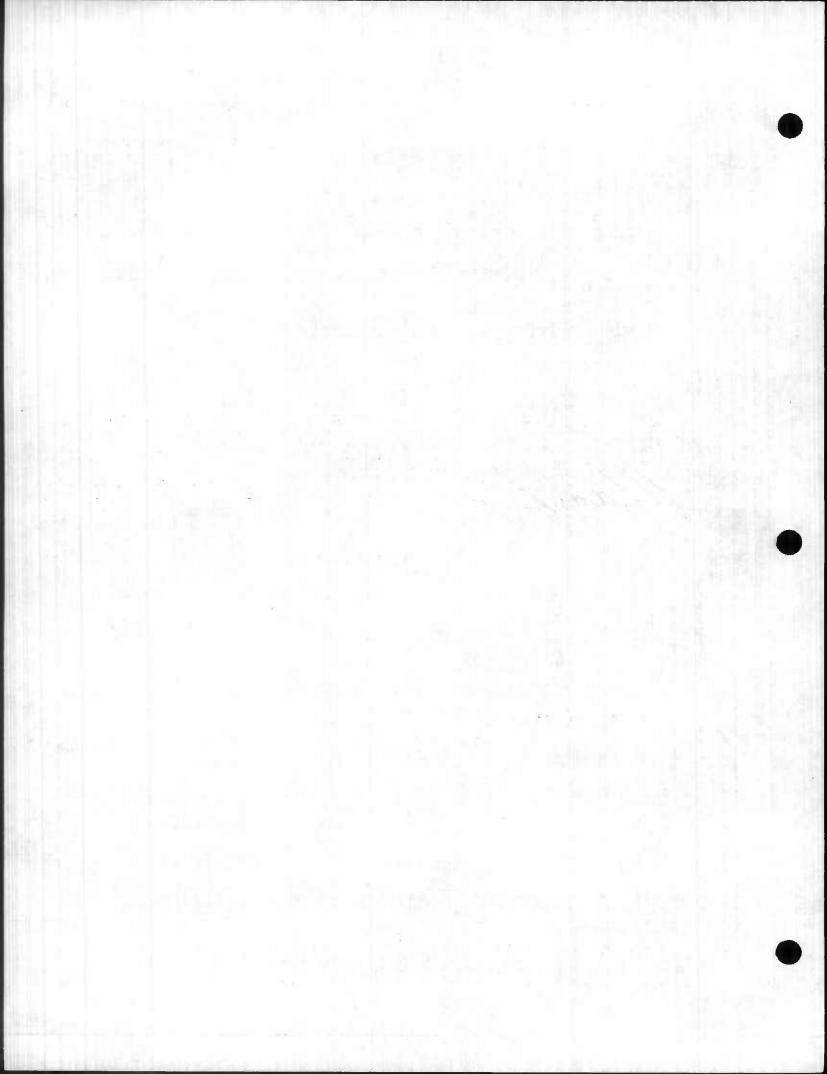
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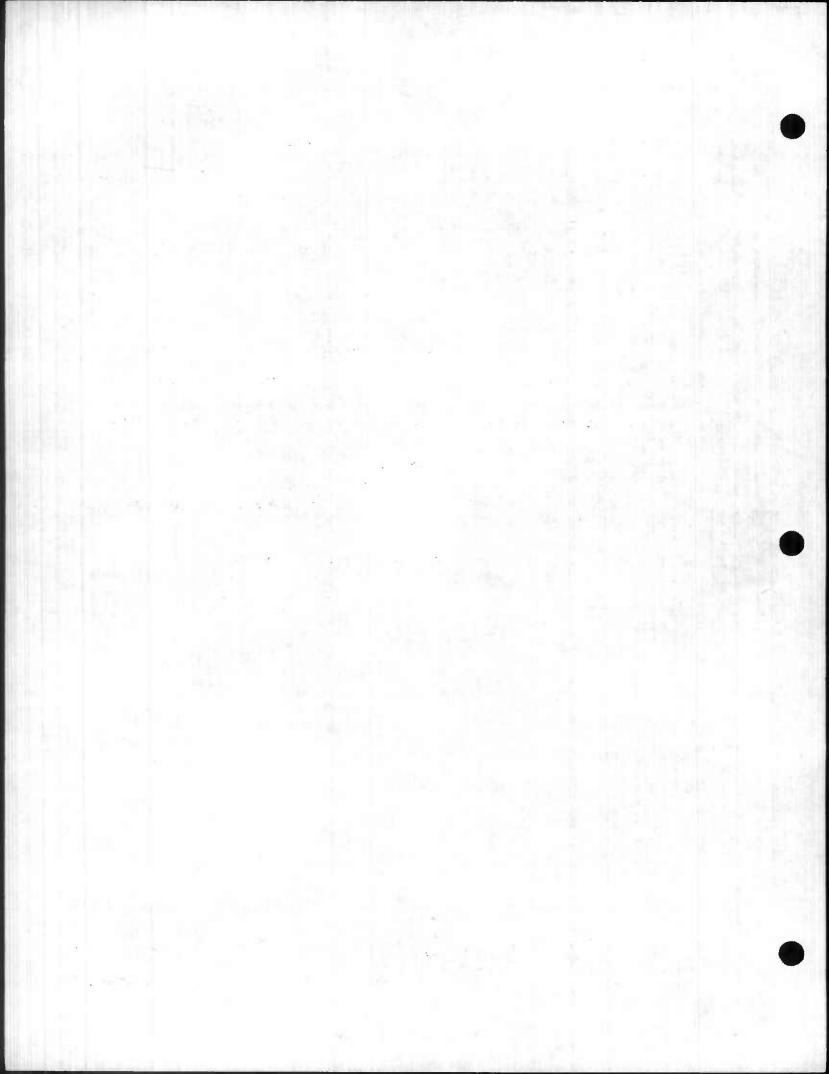
Division of Vital Records, P.O. Box 68760,

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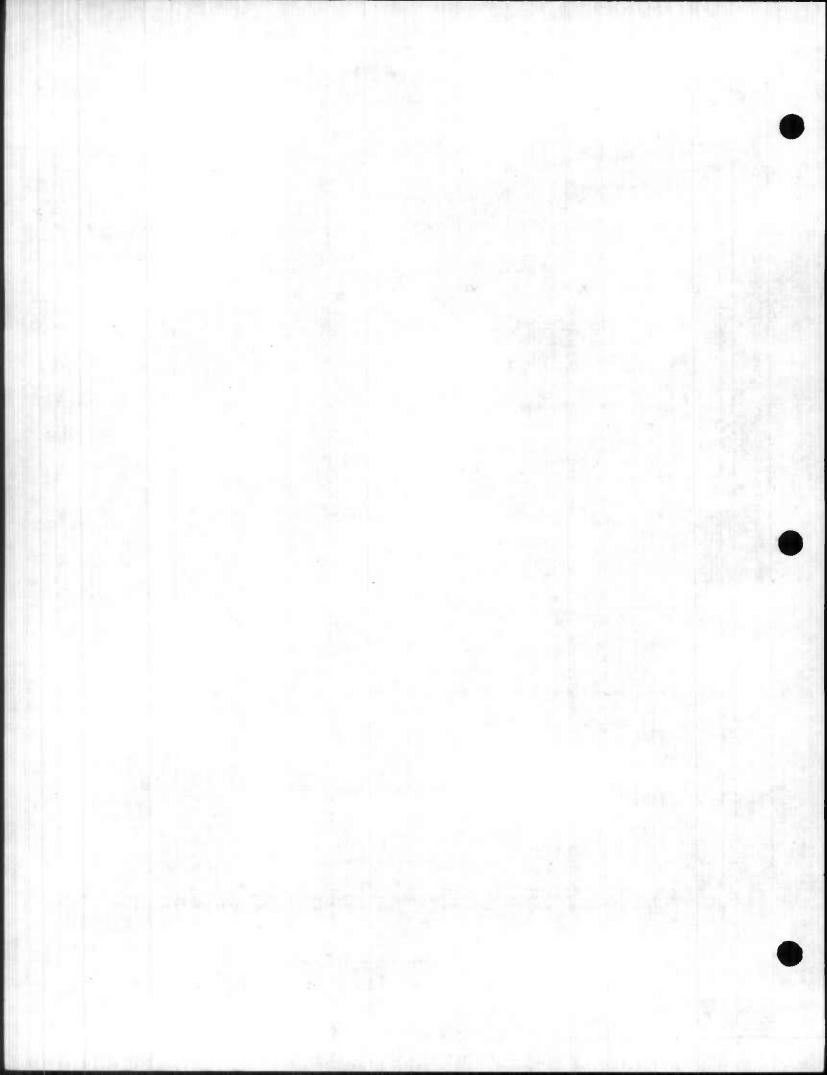
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year ALBERT BARNES JOHN December 29, 2000 5:25pm 4b. City. Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death BALTIMORE GENESIS ELDER CARE-RANDALLSTOWN RANDALLSTOWN 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Yrs. 85 DEC 21 1915 MARYLAND 219-01-9346 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No MARYLAND BALTIMORE OWINGS MILLS 10f. Zip Code 10g. Citizen of What Country? 10a. Street and Number U.S.A. 33 DEERLODGE CT 21117 12. Wes Decedent Ever in U,S. Armed Forces? 1 Ñ Yes 2 □ No If Yes, Give Year or Detes: 42/45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BETH STEEL 8th grade Blast Furnance 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) WILLIAM A. BARNES MARY BARNES 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 33 Deerlodge Ct., Owings Mills, Md., 21117 Andrew Barnes/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 5 ☐ Other (Specify) 4 Donetion GARRISON FOREST 1-5-01 OWINGS MILLS, MD Signature of Funeral Service Lie 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE Part1. Enter the distance, are repectations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. Line only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel SEPSI diseese or condition resulting in death) MEUMONIA Due to (or es a consequence of) Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed?

Physician /Medical Examiner

permit. Peges 1 and 2 should be filk Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other treumatic avent once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

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"natural", or

filed within 72 hours efter

21215-0020

altimore. Maryland

Box 68760.

P.O.

Records,

Division of Vital

Director

Funeral

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Physician/Medical þ Completed Be

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6 Hospital

> State Registrar

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes No Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one)

29c. License number

300

31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

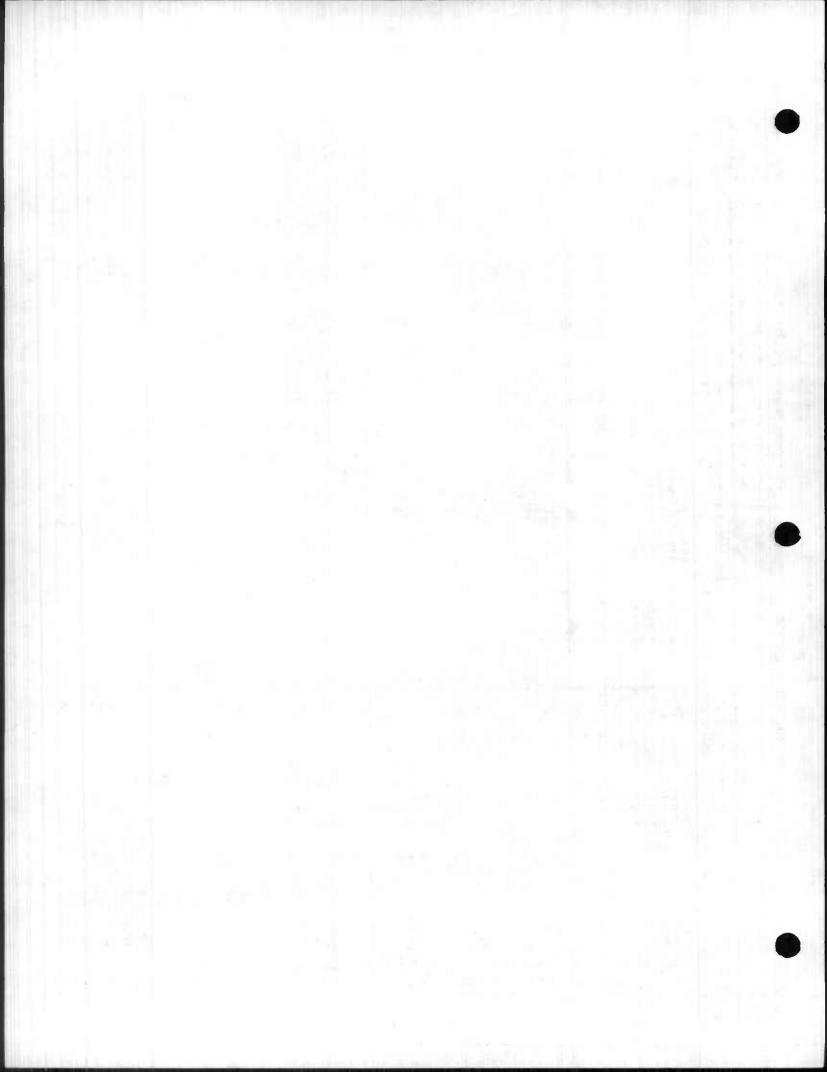
GREENE

MEZ 32 Registrar's Signeture

DS2360 SANDAIU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUSIC

29d. Dete signed (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month **Physician** Ruth H. Chason Dec.31,2000 10:54PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hart Heritage Nursing Home Harford Street If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Dec. 26, 1916 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 10 M XXF Deys Hours Months Yrs. **B4** Balto. City Director 216-12-5945 Usual Residence of Deceden 10b. County 10a. Stete 10c. City, Town or Location 10d. toside City Limits show 1 ☐ Yes 2 ☐ No Directo Harford 25a-f Md Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iner must be b 412 Stoney Brook Terrace 21047 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, al Hygiens. d other than "natural", or Items event, the Medical Examinal in 11. Merital Status Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: 72 hours after 1 Never Merried 2 Married 21215-0020 Specify: White 1 ☐ Yes 2 XNo Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12 Years College (1-4or 5+) N/A Stenographer Federal Government permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: if Nem 27 is marked other any Injury or other traument Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Unknown Herrmann Unknown 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Dalewood drive Jarrettsville, MD 21084 John Faber (CPA) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State ₩□ Buriel 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Oak Lawn Cemetery 1/4/2001 Baltimore, MD 22. Name and Address of Facility
E.F.Lassahn Funeral Home 21. Signature of Funeral Service Licenses 11750 Belair Rd Kingsville, MD 21087 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical arten Coronary Examine Due to (or es consequence Examiner physician and the burial-transit the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of) for use as signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed s certificata has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? 1 Neturet 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0047813 acharlandard, M.D. 30. Name and address of person who completed cause ot deeth (Item 23a) (Type, Print) BASHAR Smile 200 Del Air MD 21014 39 Church ville Rd. KARAKASH 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Julia Marie Creek December 26, 2000 2:45 am 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Avalon Manor Health Care Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Days 1□M 2ØF 213-74-2329 100 August 24,1900 MD Usual Residence of Deceden 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14014Marsh Pike 21742 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3. Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David H. Boden Susie Belle Garland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virgil E. Creek/Son 11745 Big Pool Road Clear Springs, MD 21722 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Cl Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Piney Plains Cemetery 12/29/00 Little Orleans, MD 21766 21. Signature of Funeral Service License 22. Nama and Address of Facility Grove Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that suised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one only on aech line. Approximete Intarval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es/a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? mle Demention 2 NO 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

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Funeral

Director

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permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 is marked of

Pages 1

Baltimore, Maryland 21215-0020

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Examine Physician/Medical by Completed 8 To Certification:

edical

State Registrar

Box 68760, Records, Vital of Division or Attanding after deeth. 24 hours • Funeral

25. Wes case referred to medical examiner? 1□ Yes 2 No 27. Manner of Death
1 Naturat
2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending investigation

6 Could not be

28a. Date of Injury (Month, Day Year)

28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28c. tnjury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

21713

12 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted.

29b. Signaturit and title of certifier

29c. License number D44996 29d. Date signed (Month, Dey, Year)
December 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Z M MALIK 20311 LAPPANS ROAD BOONESBORO, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signeture Sparker

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 605 Dey Month Year **Physician** LAVDIA CLARK 30 2000 /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner KARTIMORE MUSPITAL N/A 1 ERLY If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 10-14-1916 7. Age (In yrs. last birthdey) If Under 1 Year Birthplece (State or Foreign Country)
 N.C. 5. Social Security Number 6. Sex **Funeral** Min Days Hours 1 M 2 F Months 217-20-9598 84 NC Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Insida City Limits iens.
- than "natural", or itsers 23s or 28s-f show the Medical Examiner must be notified at ¥☐ Yes 2☐ No N/A Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 S. CHARLES ST. 21230 Funeral USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 Tho
If Yes, Give 4
Year or Detes: 14. Rece - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK by 3 ☐-Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Cottege (1-4or 5+) DOMESTIC -12--0-HOUSEKEEPING I Hygie 18 Mother's Neme (First Middle Meiden Sumeme) 17. Father's Nama (First, Middla, Last) Be and Mental marked MARION BUCK NORA GRAHAM 2 19a. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 ament of Health an .00 Nem 27 B DONNA FLYTHE (GRANDDAUGHTER) 6762 REAL PRINCESS BALTIMORE, MARYLAND 21207 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition permit. Pages Department of Important: If In any Injury or o 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State ARBUTUS MEMORIAL PARK 1-5-2001 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility REDD FUNERAL SERVICE 21. Signeture of Funeral Service Licensee wenue ealor 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Depsis Examiner Due to (or as e consequenca of): Physician/Medicai Examiner Sequentially list conditions, if any, laeding to immadiata cause. Enter Underlying Cause (Diseese or Injury that initieted avants pue buriel-tran Due to (or es a consequence of): attending physician for use as the burie Dua to (or as a consequence of) rasulting in death) Last signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown à 9 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en autopsy performed? Completed page 2 should peen After this certificate has I 2/3 No 1 Yes 2 No funeral director, Certification: To Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Menper of Death 28c. Injury et Work? 28d. Describe how injury occurred a or Attending P after death.

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2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, death occurred at tha time, date and plece, and due to the cause(s) 29e. Certifier Medicai end menner steted. 29d. Data signed (Month, Day, Year) 29c. Licanse number 29b. Signature and title of certifie MD ALO DEZ 30, 2000

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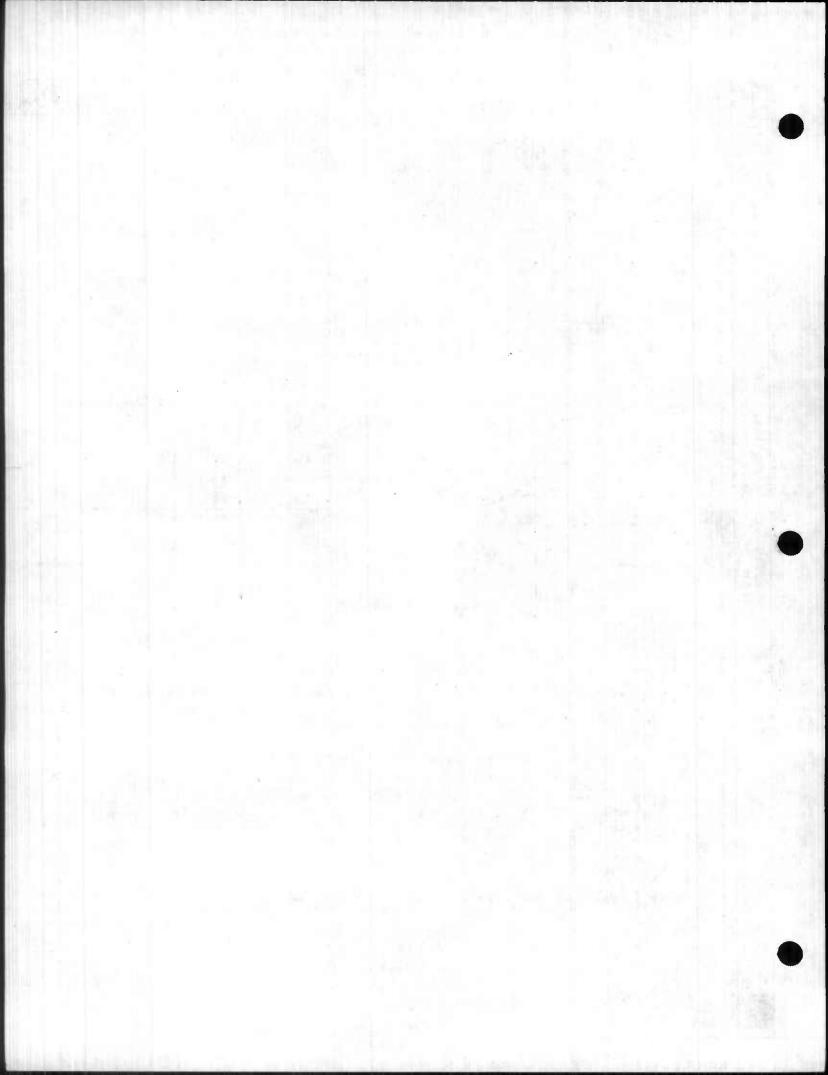
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32. Registrer's Signeture

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

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301 ST PAUL PLACE BACTIMORE, MD 21202 ourks



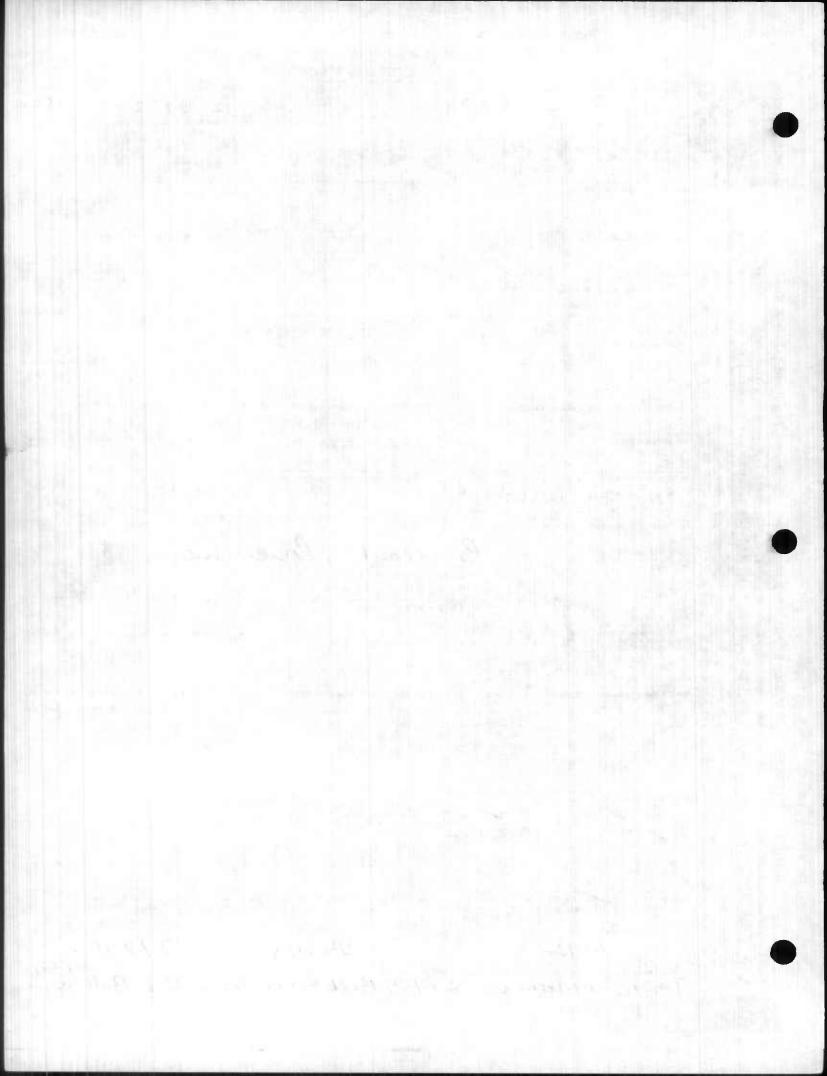
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State of Maryland / Department of Health and Mental Hygiene 0 0 4 2 2 8 0

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flar this cartificata has been signed by the attending physureral director, page 2 should be detached for use as the Completed by Physician/Medicon: To Be Completed by Physician/Medic	25. Was casa rafarrad to medical axaminar? 1 Yes 2 No 27. Menne of Death 1 Neturel 5 Panding invastigatic at Homicida 29a. Certifier (Check only one)	Hospital: 1 Despatient 28a. Dete of Injury (Month, Day) 28a. Place of Injury building, etc.	2 DER/O 28b. 7 - At home, for specify) my knowledge samination as	utpatient 3 [Tima of Injury M erm, street, factors, daeth occurre	DOA Oth-	26. Plece of D ar: 4 □ Nursing at c? Yas 2 □ No ne, data and pla	24a. Warperl 24a. Warperl 1	Yas 2 No s an autopsy ormad? Yas 2 No ona) idenca 6 Other how injury occurr (Street and Numbown, Stata)	3 Prol 24b. Wa even coo of 1 Car (Specify and	ara autopsy findin sileble prior to mpletion of cause daath? Yes 2 No No No Routa Number, liated.
in 24 hours after death. Ne Funeral Director: After this cartificata has been signed by the attending physplataly filled in by the funeral director, page 2 should be deteched for use as the edical Certification: To Be Completed by Physician/Medic	Pert II. Other eignificant conditions of the con	Hospital: 1 Despatient 28a. Dete of Injury (Month, Day) 28a. Place of Injury building, etc.	2 DER/O 28b. 7 - At home, for specify) my knowledge samination as	utpatient 3 [Tima of Injury M erm, street, factors, daeth occurre	DOA Oth-	26. Plece of D ar: 4 □ Nursing at c? Yas 2 □ No ne, data and pla	24a. Warperl 24a. Warperl 1	Yas 2 No s an autopsy ormad? Yas 2 No ona) idenca 6 Other how injury occurr (Street and Numbown, Stata)	3 Prol 24b. Wa even coo of 1 Car (Specify and	ara autopsy findin sileble prior to mpletion of cause daath? Yes 2 No No No Routa Number, liated.
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flar this cartificata has been signed by the attending physureral director, page 2 should be detached for use as the Completed by Physician/Medicon: To Be Completed by Physician/Medic	25. Was casa rafarrad to medical axaminar? 1 Yes 2 No 27. Menne of Death 1 Neturel 5 Panding invastigatic acidant 3 Suicide 4 Homicida 29a. Certifier (Check only one) 29b. Signeture and title of certifiar 30. Nema and address of person who	Hospital: 1 Despatient 28a. Dete of Injury (Month, Day) 28a. Place of Injury building, etc.	2 DER/O 28b. 7 - At home, for specify) my knowledge samination as	utpatient 3 [Tima of Injury M erm, street, factors, daeth occurre	DOA Oth-	26. Plece of D ar: 4 □ Nursing at c? Yas 2 □ No ne, data and pla	24a. Warperl 24a. Warperl 1	Yas 2 No s an autopsy ormad? Yas 2 No ona) idenca 6 Othe how injury occurr (Street and Numb wm, Stata)	3 Prol 24b. Wa even coo of 1 Car (Specify and	ara autopsy findin sileble prior to mpletion of cause daath? Yes 2 No No No Routa Number, liated.

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CIPY, PETE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #1 per phys G791 01042001 SS 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Data of Death Day 2:00 AM RANK CAMARAT **Physician** Cammarata Vecember 212000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KIVERUJEW CARE CENTER

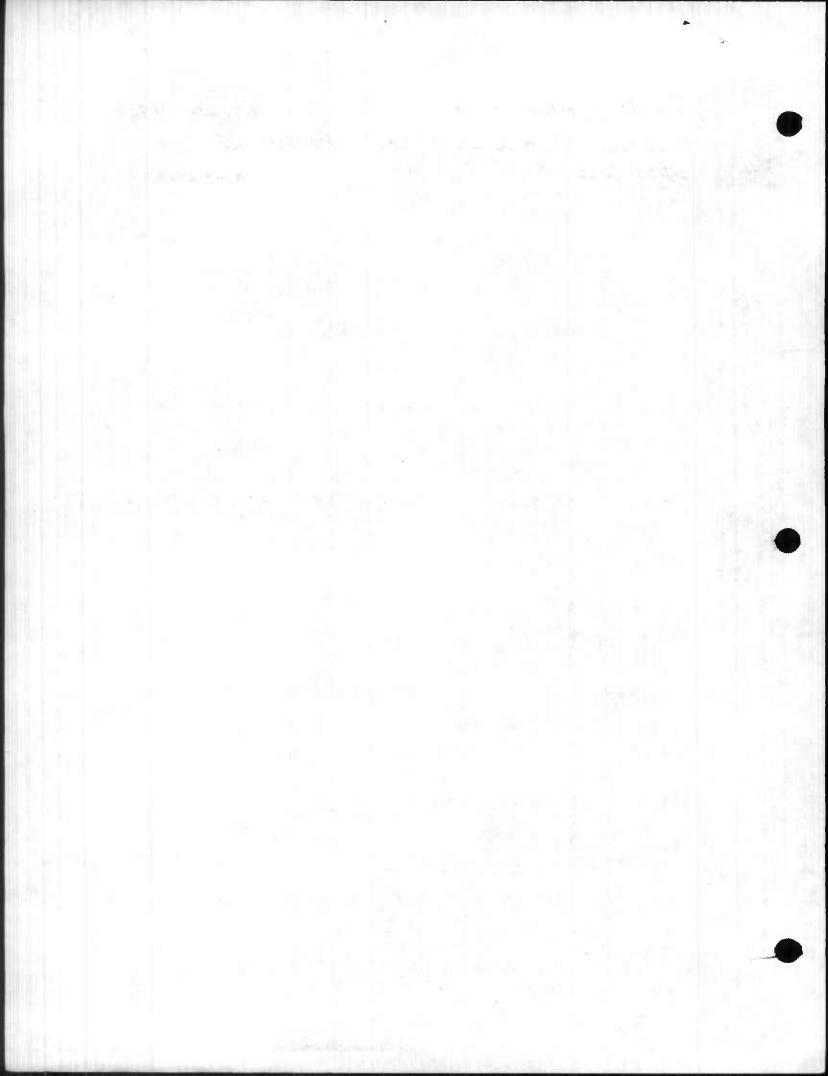
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ALTIMORE
If Under 24 Hrs. 8. Date of BALTIMORE If Undar 1 Yaar Birthplaca (Stata or Foraign Country) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Days 217-03-5624 82 MD. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at BALTIMORE 1 ☐ Yes 2XXNo MARYLAND BALTIMORE Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 212-6 U.S.A. 7120 WILLOW DALE AVENUE Funeral filed within 72 hours after death 12. Was Decedent Ever In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. 1 Yes 2000 If Yes, Giva Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry el Hygiena. Etementery/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SERVICE MAIL CLERK 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middla, Last) Be Pages 1 and 2 should be nent of Heeith and Mentel sett: If item 27 is marked o BEATRICE ANELLO GIAVANIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straet and Number or Rural Routa Number, City or Town, State, Zip Code) permit. Pages 1 end 2: Department of Heelth as Important; if item 27 is any injury or other travence. MR. LEONARD E. BATHGATE (NEPHEW) 9 FIRST AVENUE, WEST, GLEN BURNIE, MD. 21061 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 12 Bate 100 CHESAPEAKE CREMATION SERVICE, LLC. STEVENSVILLE, MD. 4 □ Donation 5 □ Other (Specify) 21. Signaline of Fanacit Service Licensee 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., talga 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part I. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Physician Immediate Cause (Final disaasa or condition resulting in death) ymphoma /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last use as the buriei-tran Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Due to (or es a consequence of): aftar death.

Director: After this certificate has been signed by the a d in by the funeral director, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ohnknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1□ Yes 2□ No 1 Yes or Attending Physician: after death. 25. Was casa referred to medicel 26. Place of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending Investigation 1 PiNature Injury 2 No 1 Yes 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homiclde To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D 43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back River Neck Rd Baltimore MD TARIG MA 31. Date filed (Month, Day, Year) MA (+mood 201-109

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State Registrar 32. Registrar's Signature



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

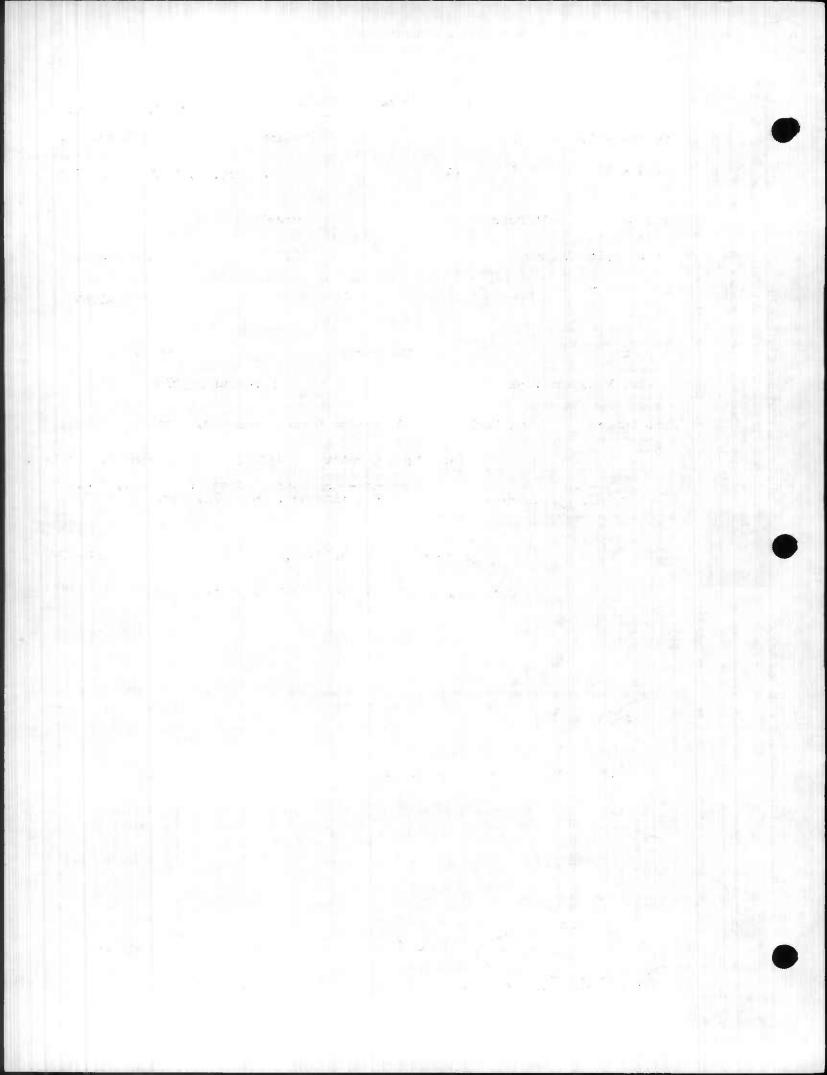
State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Day Month **Physician** Lillian Doris Duncan December 31, 2000 4:04 AM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Multi-Medical Center Towson Baltimore Co. If Under 1 Year If Undar 24 Hrs. 5 Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dev. Year) Birthplace (Stata or Foraign Country) **Funeral** Months Days Hours 1□M 2⊠ F 590-25-5174 Yrs 81 Director Nov. 9, 1919 Trinidad Usuel Rasidanca of Dacedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Insida City Limits 28a-f show ir than "natural", or items 23s or 28s-f show 1 ☐ Yas Ž No Maryland Baltimore Dundalk Direct 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? With 820 Jaydee Avenue 21222 United States Funeral 72 hours efter death 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian Black, Whita, atc. 1 ☐ Yes 2 ☑ No It Yas, Give Yaar or Datas: 1 Never Married 27 Married Maryland 21215-0020 1 ☐ Yas 2 ☐No Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 b. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturant pages." 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) Elamantery/Secondary (0-12) Collaga (1-4or 5+) 6 Years Homemaker Own Home 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Father's Name (First, Middle, Last) Patrick Coomansingh Margaret Baptise 19e. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Streat and Numbar or Rural Routa Number, City or Town, State, Zip Coda) Dundalk, Maryland Joan Duncan (Daughter) 820 Jaydee Avenue 21222 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donetion 5 ☐ Othar (Specify) 1/4/2001 Oak Lawn Cemetery Baltimore, Maryland 22. Nama and Addrass of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licenses 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Intarvel Between Onsat and Death **Physician** /Medical Immadiata Cause (Final disaasa or condition resulting in death) Examiner Examiner ears slase certificate be executed attending physician end for use es the buriel-trensit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequance ot) Box 68760 Physician/Medical Dua to (or as a consequance of) requires that the death 23b. Did tobacco use contribute to the cause of death? P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, ğ 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to Completed Mellity peen completion of cause of deeth? The law has page 2 nor Yrocadial wfarection certificate I 1 ☐ Yas 2 ☐ NO 1 ☐ Yas 2 ☐ No Physician: director. 25. Was casa ratarrad to medical axaminar? 26. Place of Death (Chack only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 | Yes 2 | → 16 this 28a. Data of Injury (Month, Dey Year) funeral 28d. Dascribe how injury occurred 27. Mannar of Deeth 28b. Time of 28c. Injury at Work? Certification: After 5 Panding invastigation 1 - Natural Attending death. 1 Yes 2 No 2 Accidant Director: 6 Could not be daterminad 3 ☐ Suicida 28t. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, tarm, straat, factory, office building, atc. (Spacify) ed in by efter 4 Homicida ŏ 24 hours Hospital 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, end due to the cause(s) and mannar as steted. 29a. Cartifian edical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one: within 2 To the F 2 29b. Signature and title of certifier. 29d. Data signed (Month, Day, Year) 2,2001 and address of person who completed aed a of death (Item 23a) (Type, Print) warte MD

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State Registrar 31. Data filed (Month, Day, Year)

4

32. Registrar's Signatura

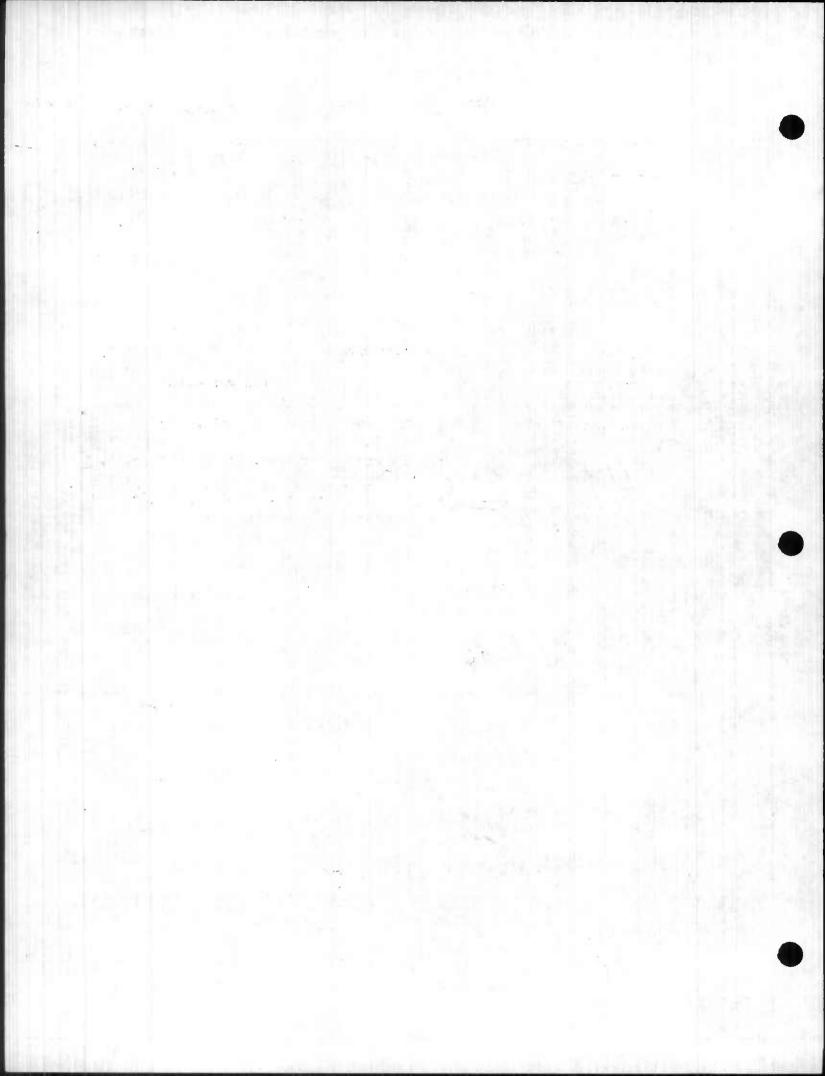


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State of Maryland / Department of Health and Mental Hygiene 0 0 42283

				Certific	cate of	Death		leg. No.	1 (2 (2 0 0
Physician	Decedent's Name (First, Middle, Las	n Cecelia	a Ai	nn I	avid		2. Date of Der Month	Day	3. Time of Dea
/Medical	4a Facility Name (If not institution, give					4b. City. Town, o	December Location of Death	er 31,	2000
Examiner	Eastpoint Nursing					Eastp			timore
uneral	5. Social Security Number 6. Sec	7. Ag	ge (In yrs. las		inder 1 Yea	r If Under 24 H			9. Birthplace (State or Fo
rector	215-05-4517 1 Usual Residenca of Decedent	□M 250F 8	16	Yrs. Mo	nths Days	Hours Mi	8. Date of Birt (Month, Da July	1, 1914	Maryland
ě u	10a. State 10b. County		10c. City,	Fown or Location	1				10d. Inside City L
to line	Maryland Balt	imore				Dunda1k			1 ☐ Yas 2 ₹
ner must be notified at uneral Director	10a. Street and Number 7314 Wenig Aven	ue		10	f, Zip Code	21222		10g. Citizen of V United	What Country?
by F	11. Marital Status 1 Nevar Married 2 Married 303Widowed 4 Divorced	12. Was Decedent Armed Forcas? 1 Yes 2 X If Yes, Give Year or Datas:				Hispanic Origin? ban, Mexican, Pur Specify:	(Specify Yas or No- arto Rican, etc.)	14. Rac Blac Specify	a - Amarican Indian, ck, Whita, etc. White
Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de complated) Cottege (1-4or		16a. Decedent's (Give kind life. DO N HOUSEW	of work don: OT use retir	upation a during most of w ed)	vorking		usiness/Industry HOME
	12 Years			nousew	TTE	19 Mathor's N	ame (First, Middle,		
To Be	17. Fathar's Nama (First, Middla, Last) Stanislaus Be	res					na Not Kr		10)
1 11 11	19a. Informant's Name/Relationship (7	ype, Print)		19b. Maiting Ad	dress (Stree	et and Number or	Rural Route Numbe	r, City or Town,	State, Zip Code)
	Robert David (So	n)				Avenue	Dundalk,		
	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cen	of Disposition netery, cremator	(Name of y or other pi	aca)	Date	20c. Location -	City or Town, State
	4 Donation 5 Other (Specify		Sacr	ed Hear	t of	Mary Cem	1/3/200	1 Dund	lalk, Marylan
9008	21. Signature of Funeral Service Licen	500	2				al Home o		lk, Inc. and 21222
व हा है। clan/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially tist conditions, if any, leading to immediate		KINS	s a consequence	0150	EASE			Onset and Deal
Physician/Medical E	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions or	d		s a consequenc		given in Part I.	23b. Did	obacco use co	entribute to the cause of d
by Phy							10	Yes 2 No	3 Probably 4 Uni
Completed t						4140		an autopsy med?	24b. Were autopsy findi available prior to complation of caus of death?
Con							10	res 20 No	1 ☐ Yes 2 ☐ No
ro Be Com	25. Was case referred to medicat examiner?						eath (Check only o	ne)	
	1 Yes 2 10	Hospital: 1 ☐ Inpati			LI DOA		Home 5 Resid		
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ly Year) 2	8b. Time of Injury	28c. Inj W	ury at ork? ☐ Yes 2 ☐ No	28d. Describe	now injury occur	rred
Certification:	3 Suicide 6 Could not be determined	Zoe. Place of th	jury - At hom tc. (Specify)	e, farm, street, f	actory, office	9	28f. Location (: City or To		ber or Rural Route Number
Medical Certification:		reician: To the best iner: On the basis of and mannar st	f examination						anner as stated. and due to the cause(s)
Z e	29b. Signature and title of certifier			Trans.	29c. Lice	nse number		29d. Date signe	ed (Month, Day, Year)
	· MA	mn	LO T		0	17945		Jan -	3 2001
	30. Name and address of person who								
11-11-					WAR	EDRIVE	FACT	MORE	mp 2123
State	31. Date filed (Month, Day, Year)	1	rar's Signatu	4	10	a Ka			

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00-6778-033 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ihm State of Maryland / Department of Health and Mental Hygiene UNK.-00-331 Certificate of Death Orlando Garcia Diaz Reg. No. 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month Day Physician ORLANDO GARCIA DIAZ NOVEMBER 28, 2000 cation of Death 4c. County of Death 2000 19:35 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) Examiner 5811 ANNAPOLIS ROAD PRINCE GEORGES 5. Social Security Number Unk 6. Sex If Under 1 Yaar 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) Un K 8. Date of Birth (Month, Dev. Year) **Funeral** Days Min 1X M 2□ F Months Hours Yrs. Director 71 July 18, 1929 Usual Residence of Decedent unk 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits unk unk 1 ☐ Yes 2 ☐ No notified Directo ã 10g. Citizen of What Country? 10e. Street and Number unk 10f. Zip Code unk unk r than "natural", or items 23s or the Medical Examiner must be r Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Un If Yes, Giva Yaar or Datas: unk Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married unk Baltimore, Maryland 21215-0036 1 No Specify: hispanic Specify: hispanic þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk filled within College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) unk per 1 and 2 should be find the set of Health and Mental H I them 27 is marked off unk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) 20b. Place of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ner 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 MOther (Specify) in state 21. Signatura of Fugeral Service Licensee Ronald S 22. Name and Address of Facility Wade Director State Anatomy Board 655 W. Baltimore Street Malle nace Baltimore, MD 21201 23a. Part Enter the disease, or complications that ceusad the death. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, shock or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . Two gunshot wounds of the Examiner Due to (or as a consequenca of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): Box 68760 that initiated events resulting in death) Last Dua to (or as a consequenca of) P.O. ed by the a 23b. Did tobacco use contribute to the cause of death? Part fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. i signed by the 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed been s this certificate has page 1 XYas 2 No 1XYes 2□ No funeral director. 25. Was case referred to medical 26. Piece of Death (Check only one) Be Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 28a. Dete of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending Injury Subject was shot 1 Natural 1 Yes 2 No 11-28-2000 1930 investigation 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number City or Town, State) 5 811 Annapolis Read 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, or Attending Physician: s after dean. To the Hospital within 24 hours a To the Funeral D completely filled in

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier OCME. NOVEMBER 29, 2000 M.D.

Prince Georges County, Many land

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hotel room

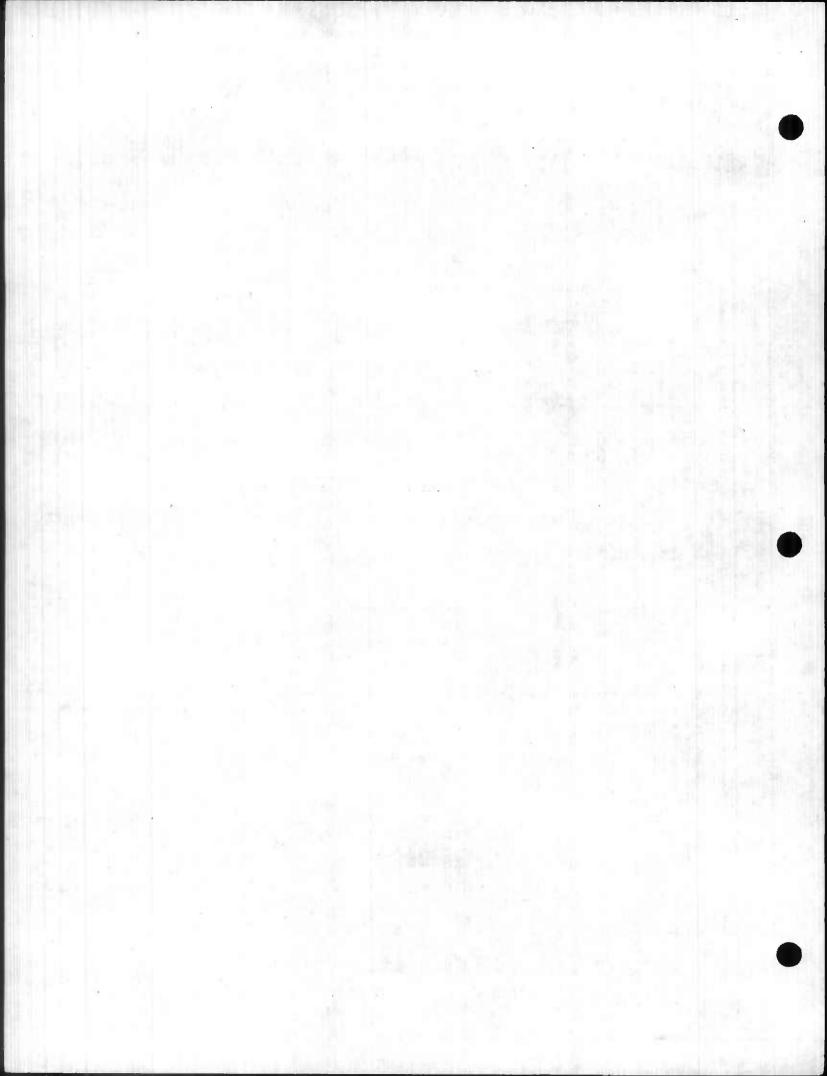
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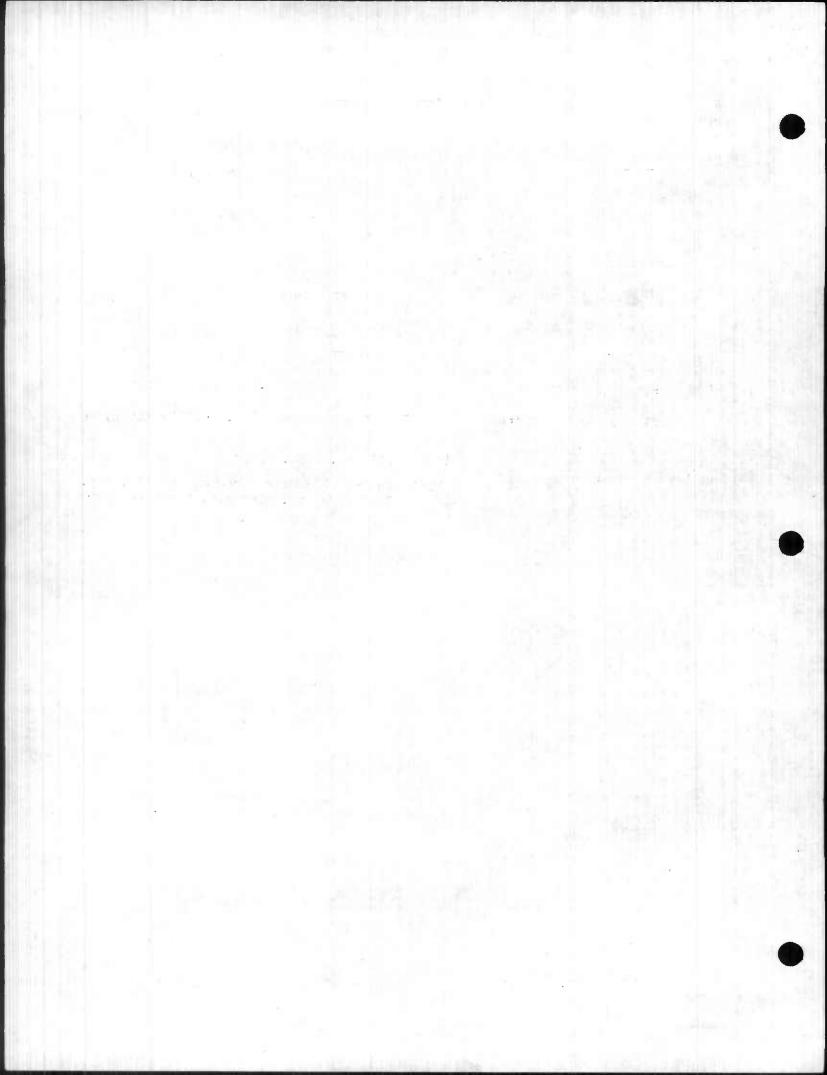
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

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111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dec. 31, Day Ruth Ann Dubit 9:18 am 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Hespital Center Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

June 17, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 M 2 F Months Hours 74 Ohio 464-44-3187 Yrs. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits Md. Baltimore Reisterstown 1 Yes 2 No 10g. Citizen of What Country? 10a Street and Number 10f. Zip Code 21136 315 Nigh Falcon Road U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Stetus Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Mousewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marion Young Earl Meyer 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Barry Bubit - Son 313 East Cherry Hill Rd., Reisterstown, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Evergreen Men. Gardens Jan. 4, 2001 Finksburg, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Eckhardt Funeral Chapel 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or treat feiture. List only one ceuse on each line. Md. 21117 Approximete triterval Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) arteres Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e opnsequence of): struct Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cone bro vascular 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy performed? lobacco add 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitet: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 2 Accident 5 Pending investigation 1 Tyes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and fittle of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

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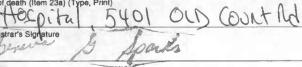
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) December 31, 2000 **Physician** 8:42 AM Tracy E. Davis /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner Baltimore
If Undar 1 Yaar | If Undar 24 Hrs. | Joseph Richey Hospice, Inc 8. Data of Birth (Month, Day, Year Oct. 1, 19 9. Birthplaca (Stata or Foraign Country) West Virginia 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2√2F Yrs. 38 213-82-8776 Usual Residance of Decedent Director 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No MD N/A Baltimore Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1226 West Lafayette St 21217 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian Black, Whita, atc. 1 Nevar Married 2 Married Specify: Black Completed by 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) WA 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Robert Lee Davis Wilma Jean Stevens 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 1226 West Lafayette Ave #3 Baltimore, MD 21217 Robert L. Davis / father 20b. Place of Disposition (Nama of cematary, cremetory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 XCramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Chesapeake Crematory, Inc 1/5/01 Beltsville, MD 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensea CAFA Stephen D. Lohrmann, P.A. Laura C. Hardesly 8717 Green Pastures DR., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Towson, MD 21286 Approximata Interval Batwean Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in daeth) Examiner Physician/Medical Examiner Sequantially list conditions, if any, leeding to immediata ceusa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of causa of death? Be Completed 24a. Was an autopsy parformad? 1 Yas 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medical axaminar? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Definer (Specify) 1 Yes edical Certification: To 27. Manner of Deeth 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 1 Natural 5 Panding 1 Yas 2 No 2 Accident 6 Could not 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data and place, and dua to the ceuse(s) end mennar as stated.

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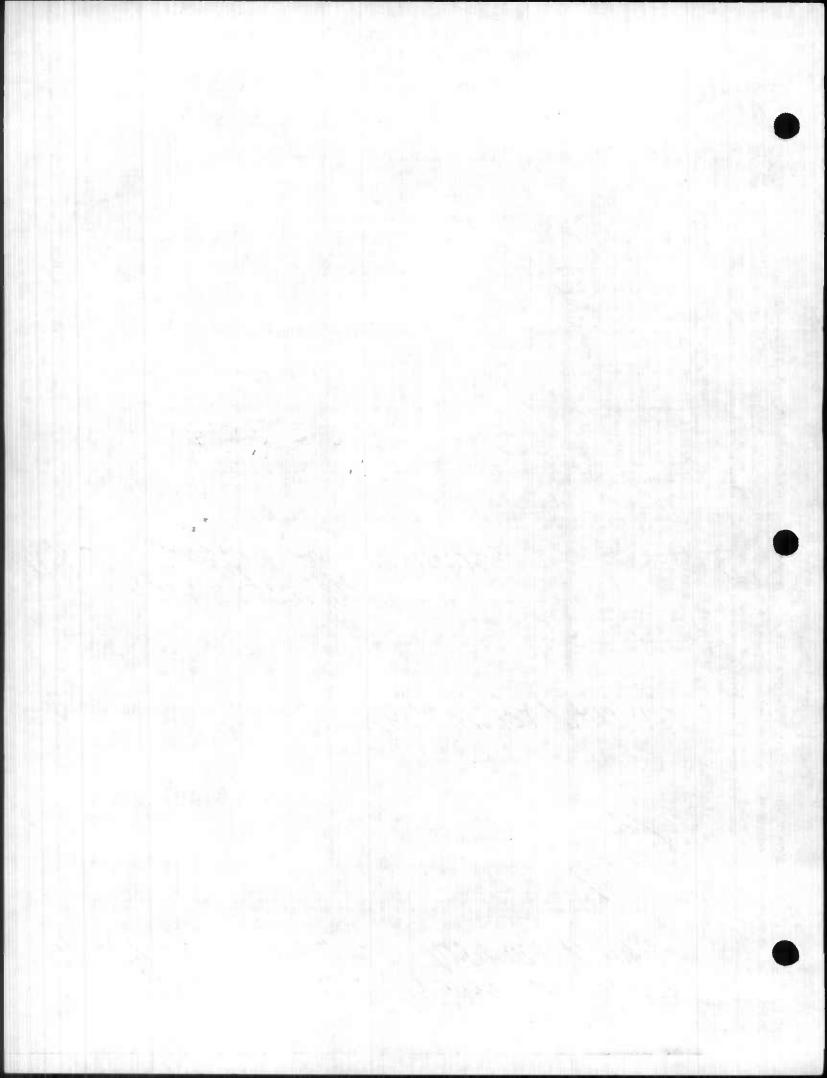
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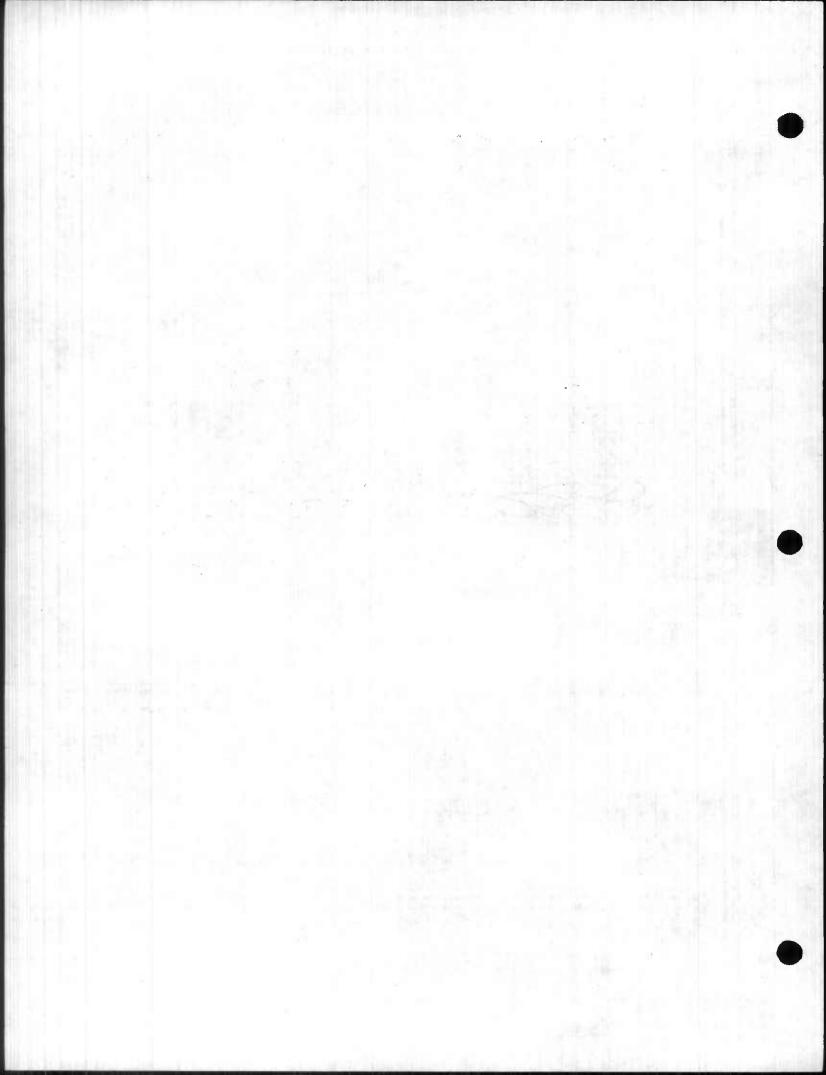


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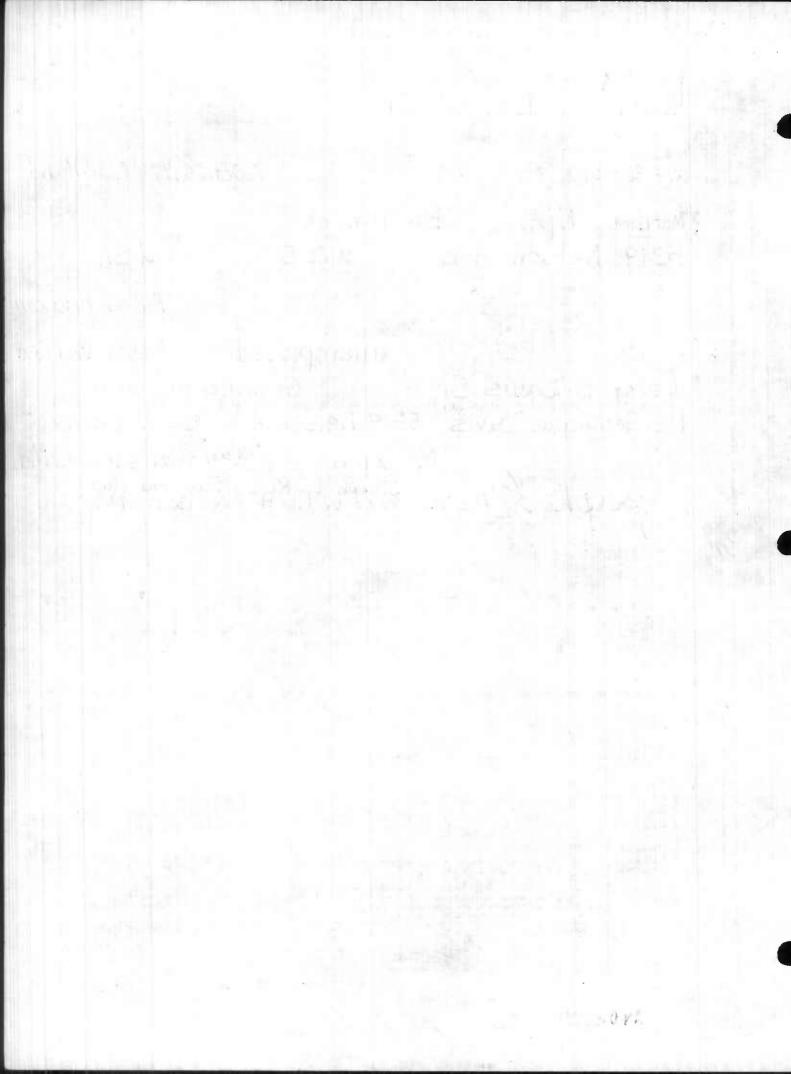
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O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

December 29, 2000

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Death 1. Decedent's Nema (First, Middla, Last) 3. Time of Death Day Month Year **Physician** Carl Froehlich George 8:05 AM December 31, 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Eastpoint Nursing Home Eastpoint Baltimore Co. If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Dete of Birth (Month, Day, Year) Funeral Deys Hours 15 M 2□ F Months 87 Yrs. 216-03-2145 Director Jan. 19,1913 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylar than "natural", or lisms 23s or 28s-f show the Medical Examiner must be notified at 1 TYes 2X No Directo Dunda1k Maryland Baltimore 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 31 Waterview Road 21222 United States Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11 Marital Status 72 hours after MXYas 2□No If Yes, Give 1942-45 1 □ Nevar Married 2 Married 1 Yes 21 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) filed within Elementery/Secondary (0-12) College (1-4or 5+) Longshoreman 8 Years Shipping Industry is marked other 17. Fether's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumeme) permit. Pages 1 and 2 should be the Department of Health and Mantai H Important. If Item 27 is marked oth any Injury or other traumatic even 88 George Froehlich Emma Nitscher 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Mrs. Dolores Froehlich (Wife) 31 Waterview Road Dundalk, Maryland Baltimore, 20b. Place of Disposition (Name of cametery cremetory or others 20e. Method of Disposition Dele 20c. Location - City or Town, State tery, cremetory or other plece) 1 Buriel 2 ☐ Cremation 3 ☐ Removel from Stete Sacred Ht. of Jesus Cem. 1/4/2001 Dundalk, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fuperal Service-Licen-22. Nama end Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part . Enter the disease, or complications that caused he deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each time. Approximete Intervel Between Onset and Death Physician Immediate Causa (Final disaese or condition resulting in deeth) /Medical CARDIOVASULAR Examiner Examiner certificate be executed attending physician and for usa as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Box 68760 Physician/Medical Due to (or as e consequence ot): 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o The law requires that the signed by to 1 No 2 No 3 Probably 4 Unknown 9 Records, p cate has been signed pege 2 should b 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? After this certificate has 2000 1 ☐ Yes 2 ☐ No 1 Yes Aospital or Attern.
24 hours after death.
- Fureral Director: After this cerning in by the funeral director, pe Division of VItal 25. Wes case reterred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 450Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 ☑ No P 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Neturel 2 17 No 1 Yes 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled roll Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner es steled.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, daeth occurred et the time, date end place, and due to the ceuse(s) and manner steled. edicai 29e. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian 29c. License number 0 411 30. Name and address of person who complated causa of death (Item 234) (Type, Print) 261

DHMH 16 Rev 6/95

State

Registrar

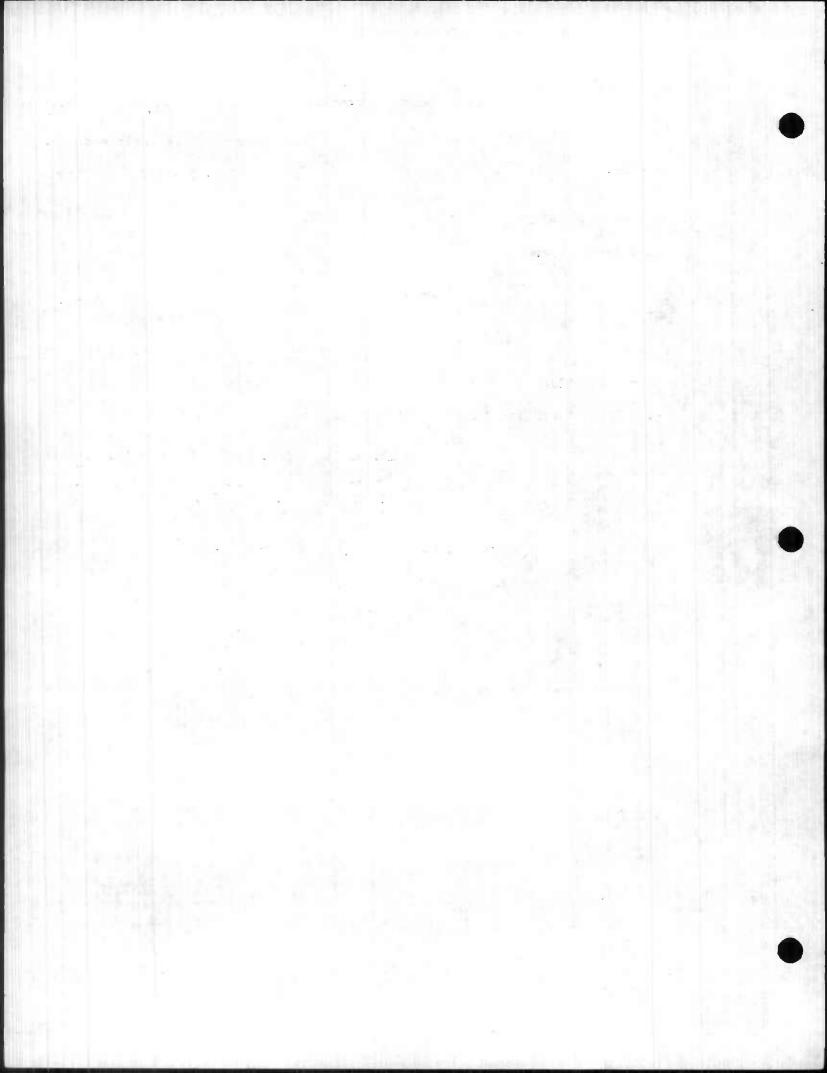
31. Data filed (Month, Day, Year)

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32. Registrar's Signatura

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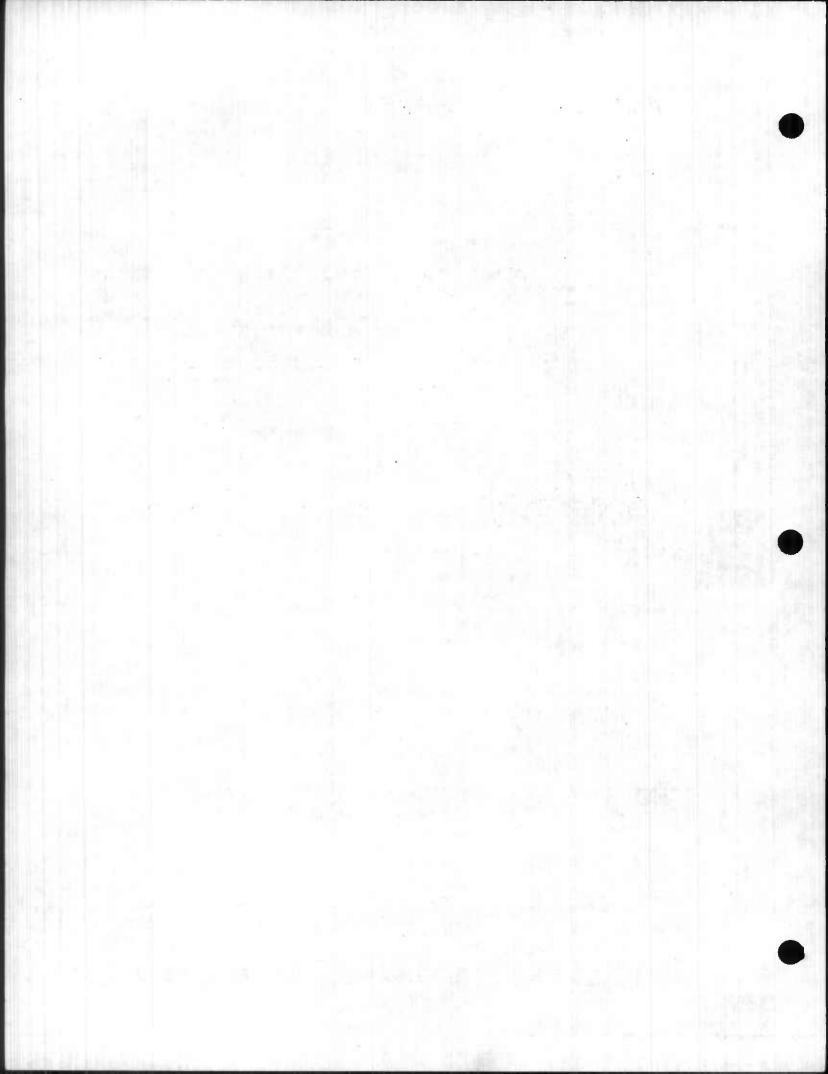


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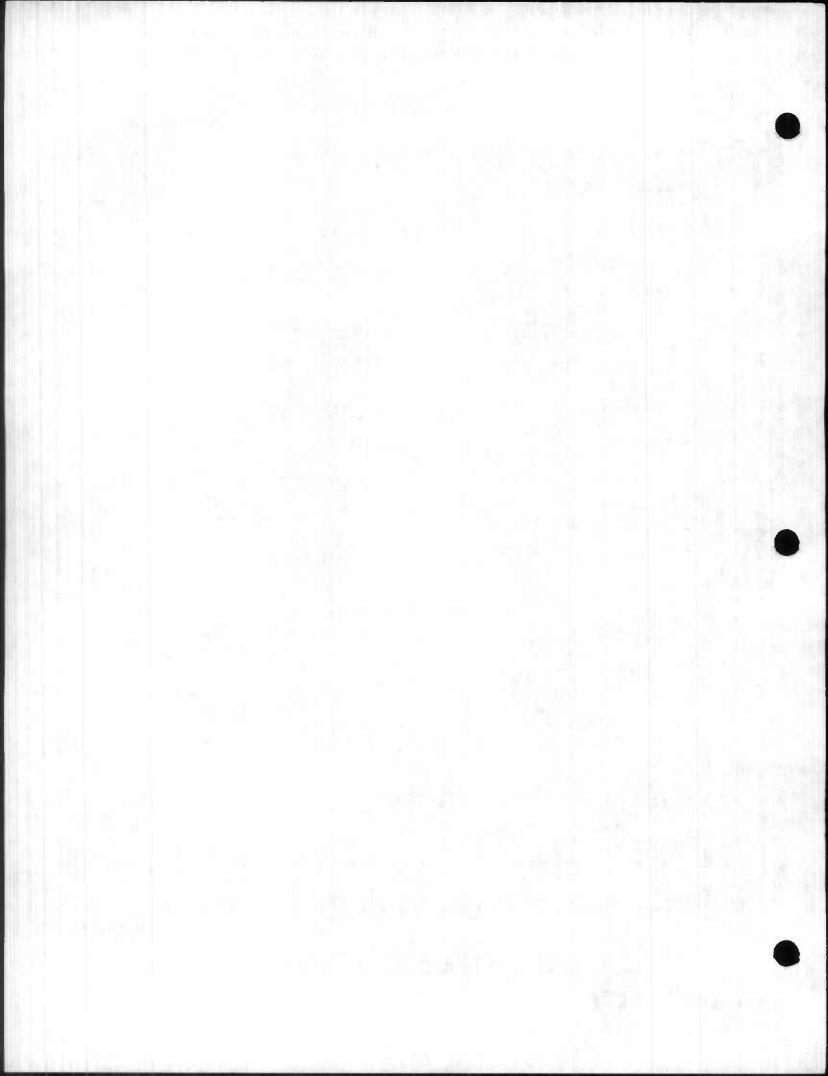
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Deeth 3. Time of Death December 31 2000 **Physician** 1:54 AM Fick Arthur H. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner Anne Arundel 7843 Bodkin View Drive Pasadena 8. Dete of Birth Year 1910 5. Social Security Number 6. Sex 1 M 2 □ F If Undar 24 Hrs. 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. last birthdey) **Funeral** Months Devs Hours 90 Yrs. 218-07-4501 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 23a or 21122 USA 7843 Bodkin View Drive Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. If them 27 le marked other than "natural", or thems 23. 12. Wes Decedent Ever in U.S. Armed Forces? 1 M Yes 2 D No. If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Water Main Elementary/Secondary (0-12) College (1-4or 5+) Foreman Installation 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Annie Shoeman Walter Fick 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: if Item 27 le any Injury or other trate Sadie Fick (wife) 7843 Bodkin View Drive, Pasadena, MD. 21122 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete Jan. 03 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Glen Haven Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 2001 Glen Burnie, Maryland 22. Neme end Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, use an each line. Onset end Deeth Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical WPP Examiner Due to (or es e consequence of) Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated avents resulting in death) Last Due to (or es e consequence of): The law requires that the death certificate be exact Box 68760. Due to (or es a consequenca of) P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? 24a. Was an eutopsy 20 No 1 ☐ Yes 2 No 1 Yes After this certificate or Attending Physician: 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Naturel 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicida 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicida within 24 hours or To the Funeral C To the Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dele end plece, end due to the ceuse(s) end manner as steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner steted. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number son who completed cause of deeth (Item 23a) (Type, Print) 6 1600 bissp Lucy so 31. Date filed (Month, Dey, Year) 32. Registrer's Signetura State 4 2001

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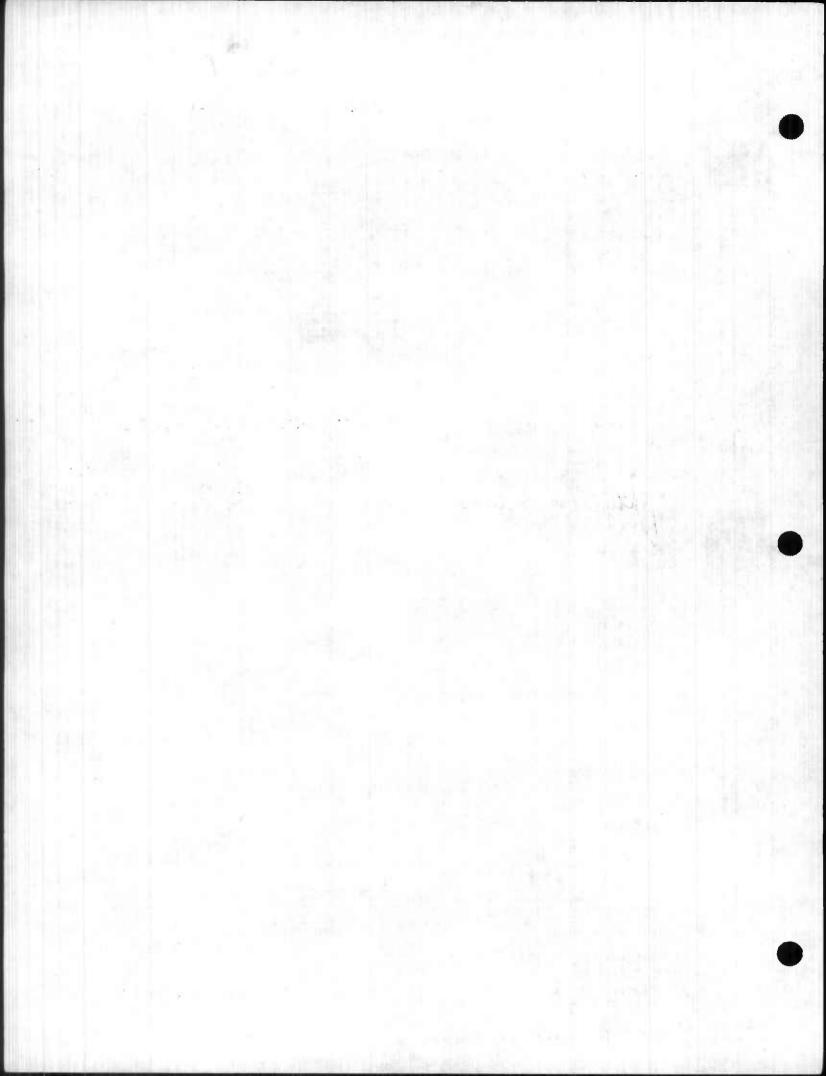
Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

NER AMENDED	S ITEMS# 23a,27,28a-f per ME	tate of Maryland / De G792 021401 SS C	partment of F ertificate of		tal Hygiene () (42293					
Physicia /Medica	to Facility Name (If not institution, give street	et and number)	FRIZNER		Date of Death Month Day DECEMBER 30, on of Death 4c, Count	Year 2000 23:49 PM y of Death					
Examine	SINAI HOSPITAL	and trainedly		BALTIMORE		N/A					
Funeral Director	5. Social Security Number 6. Sex 11 A M Usual Residence of Decedent	7. Aga (In yrs. last birthd	Months Davs	Hours Min.	Date of Birth (Month, Day, Year) C.13,1945	9. Birthplace (State or Foreign Country) RUSSIA					
aryland show after	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits					
with the Maryland a or 28a-f show Lbe notified at	MD BALTIMORE 10e. Street and Number	OWINGS				1 ☐ Yes 2)(No					
with the M a or 28a-4 Use notifie		LANE	10f. Zip Code	21117	U.S.	What Country?					
5-0036 72 hours after death w natural', or items 23a deal Examiner, must 3	11. Marital Status 1 Nevar Married 2 Married		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yas 2 🛣 No	LITITY Iispanic Origin? (Specify an, Maxican, Puarto Rican, Specify:		ca - American Indian, ick, White, etc.					
Maryland 21215-0036 d 2 should be filed within 72 hours all the and Mentia Hygiene. Trie marked other than "netural", or traumatic event, the Medical Exemptements and the medical Exemptements.	15. Decedent's Education (Specify only highast grada continues the Elementery/Secondary (0-12)	mplated) (G lift College (1-4or 5+)	ecedent's Usual Occup live kind of work done e. DO NOT use retired	during most of working	16b. Kind of E	Jusiness/Industry					
be filed the Hyg d other event,	17. Father's Name (First, Middla, Last)	Teaming at Bu		18. Mother's Name (Fi	rst, Middle, Maiden Suma						
should be	CHIAM	FRIZ		SONIA		KATLOVA					
Mar d 2 sho d 3 sho d	19a. Informant's Name/Relationship (Type, GARY MASLAN / ATT		8 EASTERN		LTIMORE, MD						
	20a. Method of Disposition	20b. Place of Di	sposition (Name of cramatory or other place			- City or Town, State					
Baltimore, semit. Peper 1 a separtment of Nes reportant: If Item my Injury or othe mas.	1 Denation 5 Other (Specify)	oval from State	AI CEMETER		2/01 OWING	GS MILLS, MD					
876(Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	ONG TERM COMPLICATION Due to (or as a continuo of the continu	ONS OF HEAD Insequence of):		spiratory arrest,	Approximata Interval Between Onset and Death					
P.O. BOX 6: thet the death certific ed by the attending p detached for use as	d Part II. Other significant conditions contrib	uting to death but not resulting in th	e underlying cause gi	ven in Part I.	23b. Did tobacco use c	contributs to the cause of death?					
C. 5 25					1 Yes 26 No	3 Probably 4 Unknown					
Records The lew requires ste has been sign page 2 should be					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?					
The le					t⊠¥es 2□No	WEGVes 2□ No					
reletan: The s certificate director, pag	25. Was case referred to medical examiner?	Sant.	lou	26. Place of Death (C	theck only one)						
SION Of tending Phys Beeth. for: After this the funerel di	1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 X Accident investigation 3 Suicide 6 Could not be 4 Homicide	y at rk? 28d Dr Ves 2 XNo CO									
25.20		8e. Placa of Injury - At home, farm building, etc. (Specify) Street			City or Town, State) Cav Balt	res Rd & Park HgtsAv					
Hospital 24 hours Funeral Hetely filled	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medicat Examiner:	in: To the best of my knowledge, d On the basis of examinetion and/o and manner stated.	eath occurred at the ti or investigation, in my o	me, date end plece, end opinion, death occurred a	aue to the cause(s) and nat the time, dete and plece	namer as stated. and due to the cause(s)					
To the To the comple	29b. Signature and title of certifier	Cheston	29c. Licens			BER 31, 2000					
State	30. Name and address of person who complete in 5 J. Chu. 31. Date filed (Month, Day, Year)	te mo 111 32. Registrar's Signatura		et, Baltimo	re, Maryland	1-21201					
Registra	I heart	Bereva /	popular	-,0							

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Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Vear Beatrice Ann Frazier 26 1:15 Am 00 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Prince Georges County Hospital Prince Geroges Cheverly If Under 1 Year Months Days 8. Dete of Birth (Month, Day, Year) January 1, 1925 5 Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 1 M 200F Hours 428-34-3861 75 Yrs. MS Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City. Town or Location New Orleans Orleans XX Yes 2 No 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 70117 1726 Feliciana Street TISA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 25 No 1 Tyes 2 No Specify: Black Specify: 3 Nowidowed 4 □ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 0 Foster Parent Foster Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Martha (Unknown) Evans Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6408 Juanita Court, Suitland Maryland 20746 Shirley Frazier Fletcher / Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State

Ph_sician /Medical

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'n any injury or other traumatic event, the Mead place.

Physician

/Medical

Examiner

10a State

LA

Funeral

Director

28a-f ehow

Director

Funeral

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Completed

7 is marked other than "naturel", or items 23s or 28s-f ebov traumatic event, the Modical Examinet must be incitited at

with the Maryland

72 hours after death

Baltimore, Maryland 21215-0020

Examiner and certificate be

Examiner

Physician/Medical

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Certification:

Medical

physician e s the burialattending pl å signed by to d be detach been s 7 page 2 certificate 星 Attor

Mount Clivet Cemetery Jan. 3 Zool 1 Burial 2 Cremation TRemoval from State New Orleans, LA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 C 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final STATUS EPILEPI CUS disease or condition resulting In death) Due to (or as a consequence of): ANOXIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last Due to (or as a consequence of). Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of ceuse of death? 2 1000 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medicel 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Box 68760 Records, P.O. The law Division of Vital Physician: Attending Director: after A 24 hours a Funeral (Hospital

29a. Certifier (Check only one)

27. Manner of Death

1 Naturel

2 Accident

3 Suicide

6 Could not be determined 4 Homicide

5 Pending

investigation

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury et Work? 1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Berhane 3001 Hosp. Drive Cheverly mi) ISION MO

31. Date filed (Month, Day, Year) JAN 04

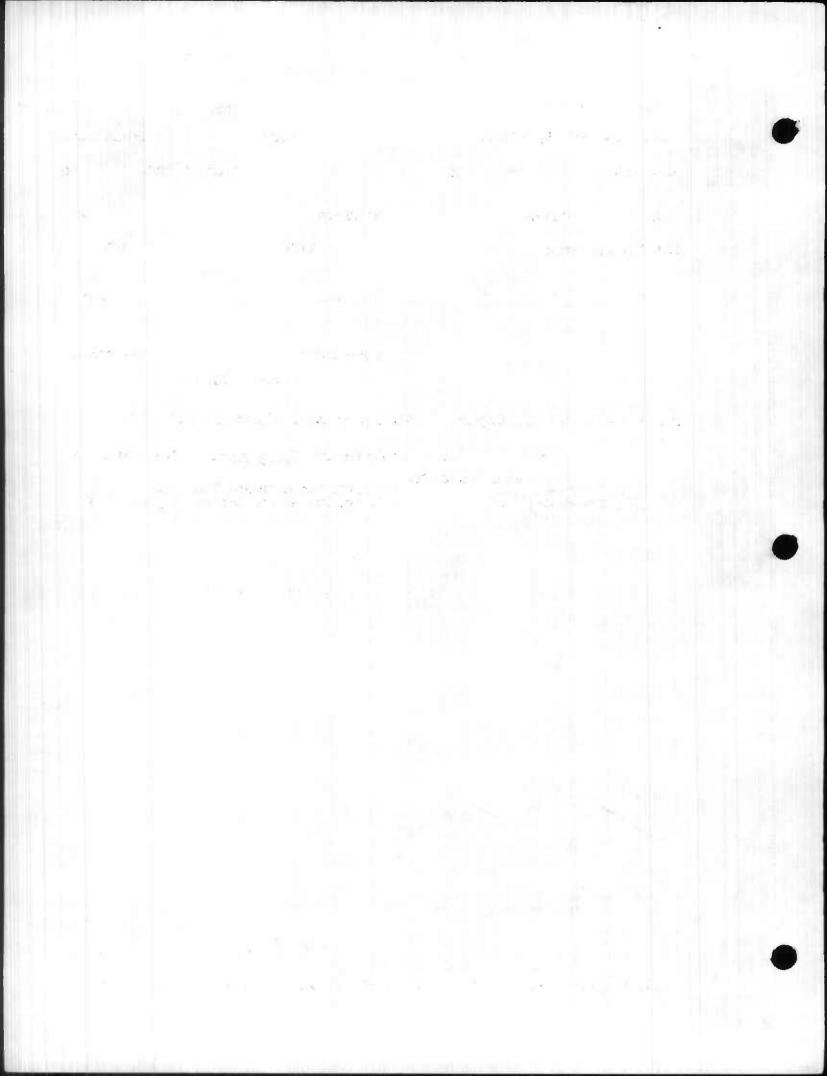
32. Registrar's Signature

Registrar

State



Within 2 To the



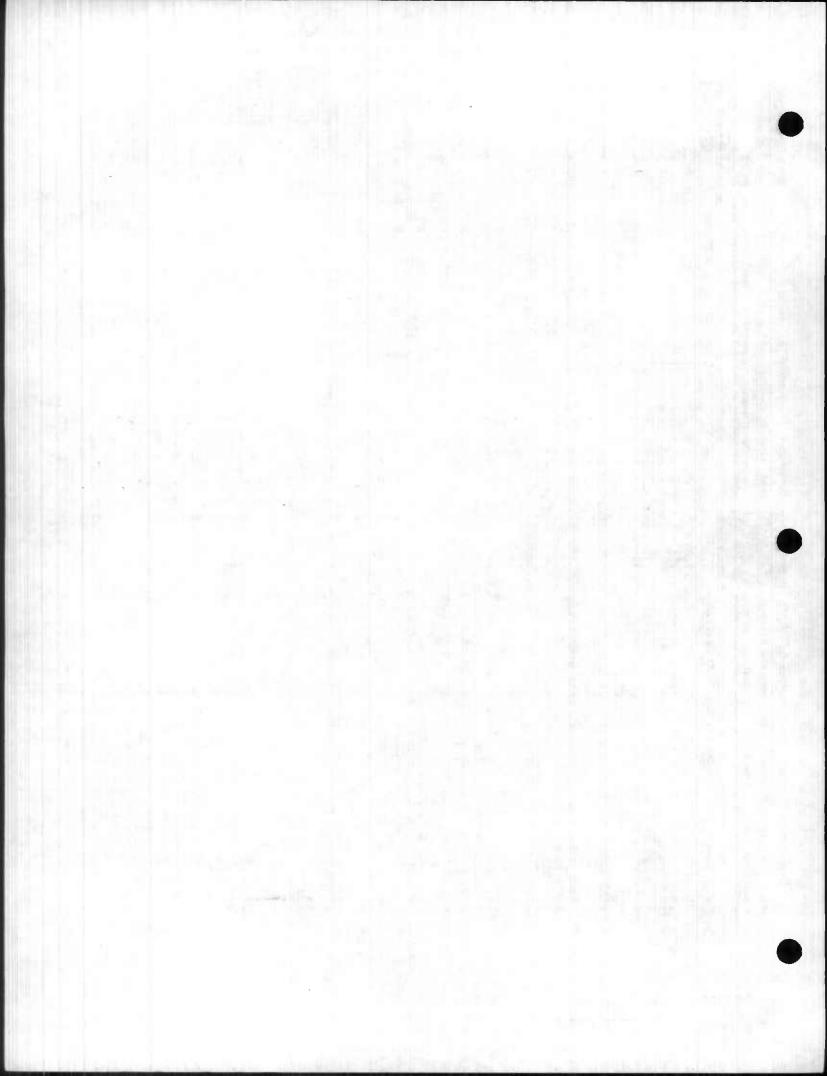
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death AMENDED ITEM #31 per DVR G791 01-04-01 SS 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death **Physician** Mary C. Gillease 29 December 2000 1:00a.m /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Days Hours 215-01-0496 Yrs. Director June 1, 1916 Maryland 84 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits 28a-f show 1 N Yes 2 No 7 is marked other than "natural", or flams 23s or 28s-f i traumstic event, the Medical Examinat must be notified Baltimore City Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 815 South Eaton Street 21224 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify P 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 2 Years Homemaker Own Home Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surname) and Mentel Mary Hedl Charles Rentz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Unit301 19a. Informant's Name/Relationship (Type, Print) 12310 Rosslare Ridge Road Timonium, MD of Health Michael Gillease (Son) Baltimore, 20b. Placa of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition permit. Pages Department of Important: If its any injury or o 0 1 Burial 2 □ Cramation 3 □ Ramoval from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 1/2/2001 21. Signature of Buneral Service Licensee 22. Name and Addrass of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland ter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, than the mode of dying, such as cardiac or respiratory arrast, than the mode of dying, such as cardiac or respiratory arrast, Approximate Interval Batw Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical O U revious Cancel Examiner Dua to (or as a consequance of): Physician/Medicai Examiner Mulfi or gon Due to (or as a consequence of): The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate causa. Entar Undarfying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. ettending physician for use es the buna Moselin Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yss 2 No 3 Probably 4 Unknown Inpertension Division of Vital Records, À 24a. Was an autopsy performed? 24b. Were autopsy findings Completed available prior to completion of causa of death? 1□ Yas 2□ No 1 ☐ Yes 2 ☐ No Physician: 25. Was case refarred to medical Be 26. Place of Death (Check only ona) Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 10 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred Certification: After Attending 5 Panding investigation 1 Natural ours after death. eral Director: Affilled in by the fu 1 Yes 2 No 2 Accident 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 6 within 24 hours a
To the Funeral Completely filled 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a: Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licanse number MID 30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print) 7801 you KRJ. TOWOON -M.). 21204 RAZZAK 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 0 4 2001

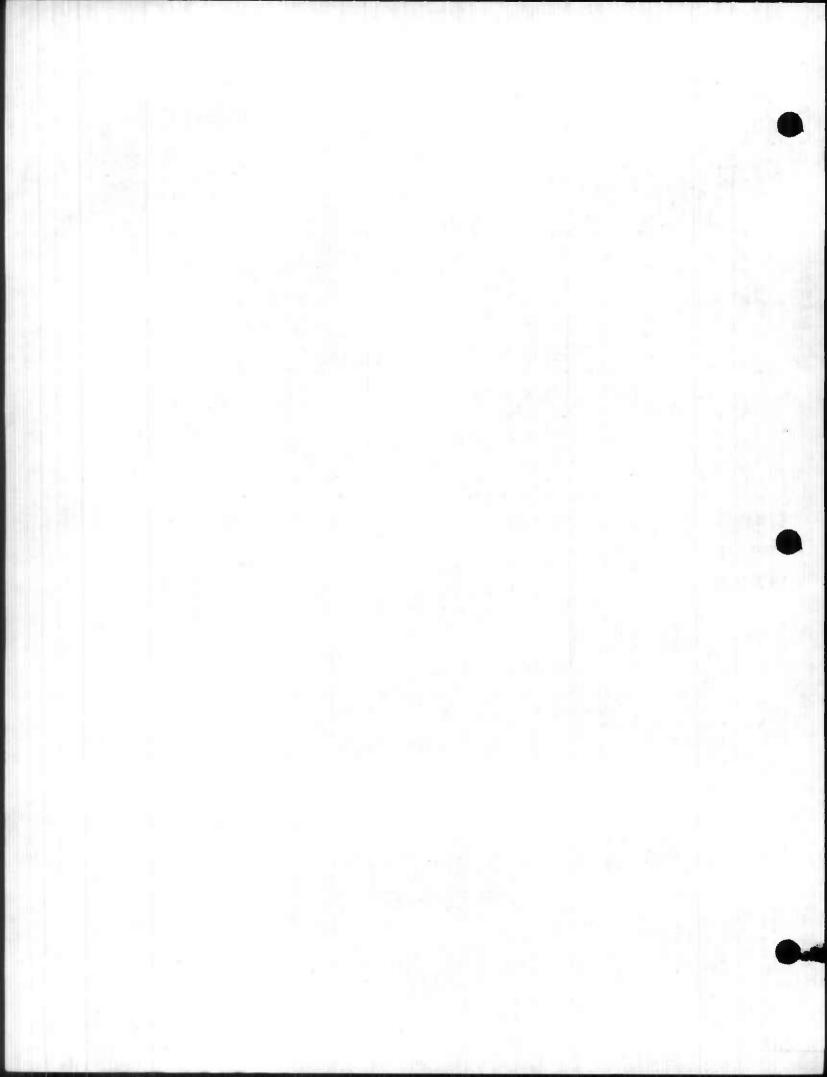
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State of Maryland / Department of Health and Mental Hygiene 00 42296 Certificate of Death

Physician /Medical	Decedent's Name (First, Middle, Las CLARENCE		In.	iouto or		2. Date of Dec Month Decemb	Day	3. Time of Death 20:55 (8:55 p.m					
Examiner	4a Facility Name (If not institution, give Harbor Hospi	street end number) tal Center			4b. City, Town, or L Baltin		4c. County						
Funeral Director	5. Social Security Number 6. Social Security Number 214-40-3514		rs. last birthday) If	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, De 4-28-]	v, Year) 943	Birthplace (State or Foreign Country) VA •					
anyland show	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Location	on				10d. Inside City Limits					
the Man 288-1 sh returned	MD. N/A	В	ALTIMORE					1 ☐ Yes 2 ☐ No					
flar deeth with the Mai flame 23a or 28a-f s finer mart be rediring funeral Director	10e. Street and Number	P	1	Of. Zip Code			10g. Citizen of W	/hat Country?					
ne 234	2547 LAURETTA AV	12. Was Decedent Ever in	U.S. 13. Was	21223		pecify Yes or No	USA 14. Race	- American Indian,					
o o o o o o o o o o o o o o o o o o o	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		s, specify Cubi	dispanic Origin? (Span, Mexicen, Puerto Specify:	Rican, etc.)		Black, White, etc. Specify: BLACK					
72 ho	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent	of work done	during most of world	king	16b. Kind of Bu	siness/Industry					
yland 21215-0 uld be filed within 72 ho Mentel Hygiene. riked other then 'natur ritic event, the Healise! To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired EMAN	d)	91	ROOF	TNG					
and 212 be filed with the Hygiene event, the be	17. Father's Name (First, Middle, Last)		FOR	DIMIN	18. Mother's Nam	ne (First, Middle,							
should be and Mentel marked or marked or marked or marked or marked or To Be	CLARENCE GRAY SR	•			ISABE	LL MAYFI	ELD						
Mar nd 2 sho nd 2 sho th and th and traums	19a. Informant's Name/Relationship (7 ISABELL GRAY (MOT			,	end Number or Ru TA AVE.			State, Zip Code) LAND 21223					
Baltimore, semil. Pages 1 er sepertment of the mportant: If item iny injury or other	20a. Method of Disposition 1 Burial 2 Operation 3 4 Donation 2 Other (Specify		- City or Town, State ORE, MARYLAND										
Baltim permit. Pa Depertment Important: any injury pncs.	21. Signature of Funeral Service Licentary	J. Hisn						HOME, P.A. MARYLAND 21217					
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Acute Due to Sepsis	Myocaro o (or as a consequer o (or as a consequer o (or as a consequer	hal sumonion of the office of	Infarctio a	n		one day 5 days					
Nox 68760, th certificate be executed sending physician end ruse es the burial-transit anvMedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	cDue to	o (or as a consequen	ce of):									
cords, P.O. Borduires that the deeth reen signed by the attenhould be datached for eted by Physicia	Part II. Other significant conditions on	ontributing to death but not	resulting in the unde	rlying cause giv	ven in Part I.		tobacco uss cor Yes 2□ No	ntributs to the cause of death?					
Vital Records, liden: The law requires to certificate has been signe rector, page 2 should be to Be Completed by						24a. Was	an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?					
The law ate hes b page 2 s						10	Yes 2 No	1 ☐ Yes 2 No					
Vital Ricen: The I certificate he rector, page	25. Was case referred to medical examiner?	Hospital:		011	26. Place of Des								
hys his ald	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year	28b. Time of Injury	28c. Inju	4 U Nursing H		dence 6 Oth						
fic state of the	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, street, ecify)	lactory, office		28f. Location (City or To		er or Rurel Route Number,					
Hospi 14 hours Funer taly fill	29a. Certifier (Check only one) 12 Certifying Phytone) 14 Certifying Phytone	ysicien: To the best of my liner: On the basis of exam and manner stated.	knowledge, death oc ination and/or invest	curred at the ti igation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)					
To the within 2 To the comple	29b. Signature and title of certifier	.1 1.	0	29c. Licens				d (Month, Day, Year)					
	Loursh Di	hay, m.	D.	Kes	001		Decemb	er, 30, 2000					
8	30. Name and address of person who of KOUROSH DIBAD	completed cause of death (I	Item 23a) (Type, Prin	ver st	reet, Ba	ltimore	, MD -	21225					
State	31. Date filed (Month, Dey, Year)	32. Registrar's Si	onature /	Spor	Cs Cs								



Ple

	Plea	ase Ty	pe or f	Print In B	Black In	idelibi	e Ink	. Assu	ıre A	II Coples	s A	re Legi	ble.	
				Maryland	d / Depa	artmen	nt of H	Health a	and N			0.0		2297
					Ce	rtiticat	e or	Death			Reg	g. No.	-	
1. Decedent's Nem	e (First, Middl	le, Last)	man,		1013	77				2. Dete of Do	eeth	Dev	Year	3. Time of Death
Thomas G.	. Graha	ım								August	1 1	10, 200	00	6:30 P.M.
4e Fecility Neme (If not institution	n, give stre	et and num	iber)				4b. City, To	wn, or L	ocation of Dee	ith	4c. County	of Death	
Casey Hou	use-600	1 Mur	ncaste	er Mill	Road		7	Rockv	ille	:		Montgo	omery	4
5. Sociel Security N		6. Sex	7	7. Age (In yrs. I			r 1 Year		24 Hrs.	8. Dete of Bi	irth	Voorl	9. Birth	place (Stete or Foreign
123-20-16	636	1 % O M	4 2□ F	71	Yrs.	Months	Deys	Mours	Min.	Nov.	30,	1928	New	York, NY
Usuel Residence o														
10a. Stete	10b. County			10c. City	y, Town or Lo	ocation								10d. Inside City Limits
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	De. Street and Number				95	10f. Zip					100	g. Citizen of V	Whet Cou	intry?
19316 Dui	nbridge	e Way				20	0886				J	J.S.A.		Maria Tara
11. Meritel Stetus		12.	. Wes Deced	dent Ever in U,	S. 13.	Was Dece	dent of F	Hispanic Ori	igin? (Sp	pecify Yes or N	10-		ce - Ameri ck, White,	icen Indien,
1 Never Men	ried 20 Man		1√ Yes 2	2 No									, etc.	
3 ☐ Widowed	4 Divorced	1	ff Yes, Give Yeer or Det	e etes:1954/	56	1LI Yes	2)(1 No	Specify:				Specify	Wh:	ite
(Spe	15. Deceden	nt's Educeti	tion		16e. Dece	16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working								
Elementary/Seco	ondary (0-12)		College (1~	-4or 5+) ears		hologi	The state of the s	a)				U.S. (Gove	rnment
17. Fether's Neme	(First, Middle,	, Last)					7	18. Moth	er's Nem	ne (First, Middle	le, Ma	aiden Suman	ne)	
William	Graham	> .						Lou	ise	Hurbert	t			
19e. Informent's N	eme/Reletions	ship (Type,	Print)		19b. Meili	ing Addres	s (Street	t and Numb	er or Ru	iral Route Numi	ber,	City or Town,	State, Zi	ip Code)
Matthew .	A. Hint	ton-M	ortua:	ry Off.	3700	O N. (Capi	tol S	tree	et, NW,	Wa	ash., I	DC :	20317
20a. Method of Dis	sposition			20b. Pl	Plece of Dispo	osition (Nat	me of	ecal		Dete	20	Oc. Location -	City or T	own, State
	Cremetion 5 Other (S		ovel from S	Stete	sapeak				18	8/15/00	Be	eltsvi	lle,	MD
21, Signature of Fr	uneral/Service	Lidensee			2	2. Name er	nd Addre	ess of Fecili	ty T.a	atney's	F	uneral	Hom	e. Inc.
John.	10to	elu	4	Q ccc	348 38	831 G	eorg	jia Av		NW, Was			200	
23a. Pert1. Enter t shock, or hee	the diseese, or art feilure. List	complicat tonly one (ions that ce	sused the deeth ach line.	. Do not en	ter the mod	de of dyir	ng, such es	cardiec	or respiretory	erres	at,	1	Approximete Interval Between Onset end Deeth
Immediate Cause disease or condition resulting in death)	on	a	Metas	tatic A	denoc	arcin	oma						1	
				Due to (or	er es e conse	quence of)							1	
		a b :	Prost	ate Can	cer								1	2 years
Sequentially list co	onditions, mmediete			Due to (or	r as e consec	quenca of):								

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

by

Completed

Be To

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiena. Important if Item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, the Medical Exemples must be notified at other

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the tuneral director, page 2 should be detached for use as the bunia-Iransit

Division of Vital Records, P.O. Box 68760.

edical Certification: To Be Completed by Physician/Medical Examiner

shock, or heert feilure. List only	one dause on each line.	or respiretory errest,	Interval Between Onset end Deeth					
Immediate Ceuse (Finel disease or condition	Metastatic Adenocarcinoma							
resulting In death)	Due to (or es e consequence of):							
	Prostate Cancer		2 years					
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as e consequenca of):							
thet initieted events resulting in death) Last	Due to (or es e consequenca of):							
Pert II. Other significant conditions of Pathologic Fract	contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobecco use cor 1 ☐ Yes 2√ No	ntribute to the cause of death					
		24a. Wes en eutopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 Yes 2 No					
25. Wes case referred to medical	26. Place of Dee	th (Check only one)						
examiner? 1 Yes 2 No	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 ☐ Residence 6 🖺 Other	er (Specity) Hospice					
27. Manner of Deeth 1 □ Neturel 5 □ Pending 2 □ Accident investigation		28d. Describe how injury occurr	ed					
3 ☐ Suicide 6 ☐ Could not to determined		28f. Location (Street and Numb City or Town, State)	er or Rural Route Number,					

29b. Signeture end title of certifier

29e. Certifier

MD

29c. License number D09470

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end menner steted.

29d. Date signed (Month, Day, Year)

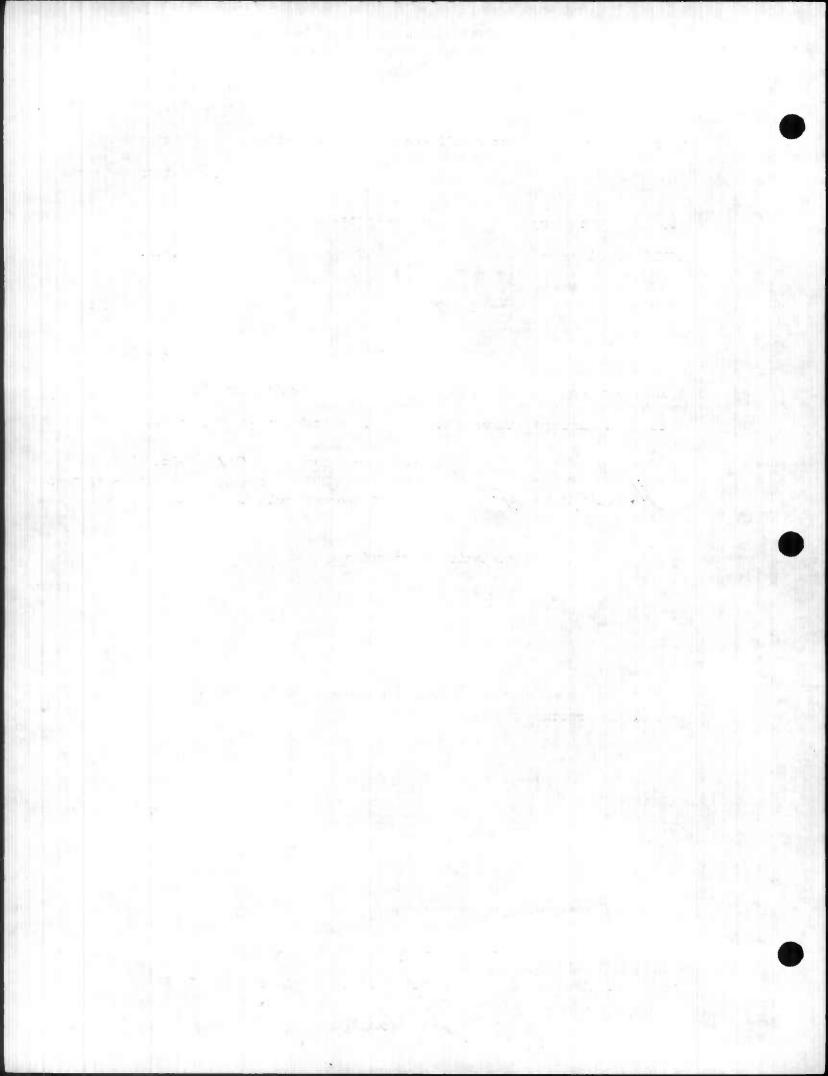
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

20895 10400 Connecticut Ave., Kensington, MD Eugene P. Libre MD

State Registrar

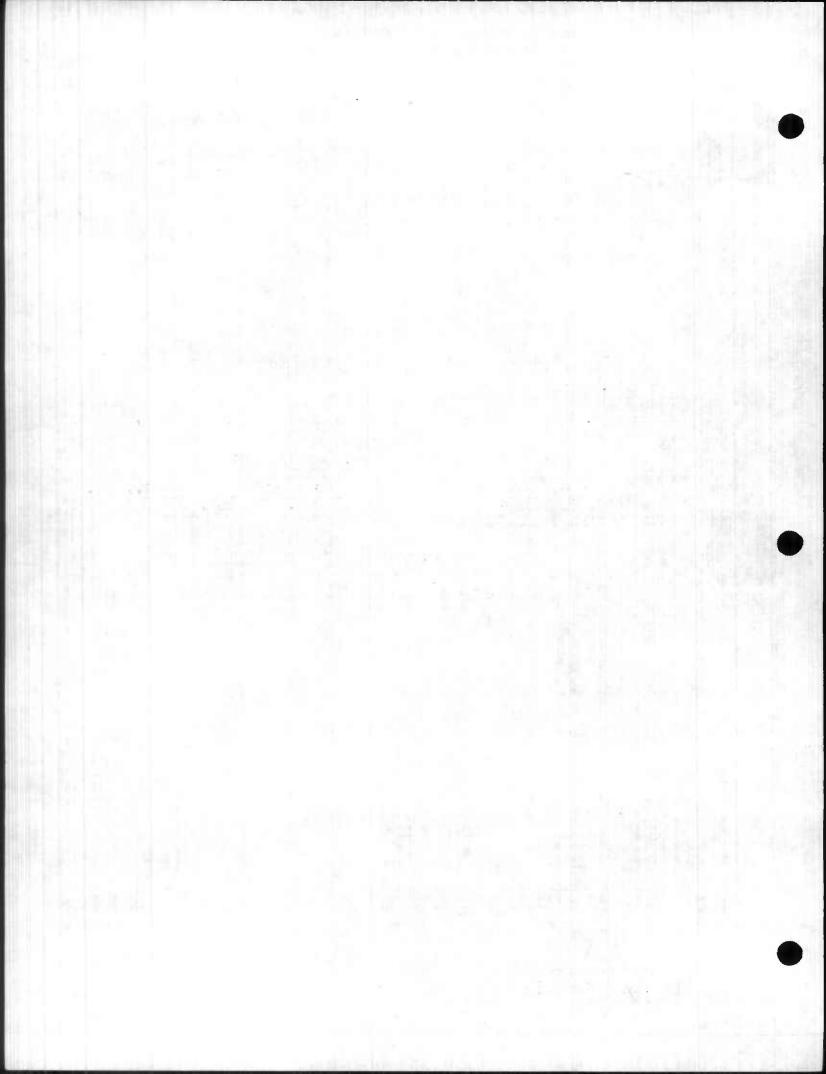
31. Dete filed (Month, Day, Year) JAN 0 4 2001

32. Registrer's Signeture



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ector	Usual Resident	ce of Decedent			86				1		July	6, 1914	Ma	ryland
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or name 23a or 28a-1 snow miner must be notified at 7 Funeral Director	Maryla	nd B	altin	nore				Mi	ddle	Rive	r			1 ☐ Yes 2 🔼
be notified	10e. Street and	Number					10f. Z	ip Code			2 000	10g. Citizen of	What C	ountry?
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iner must	11. Marital Stat	lus	12	2. Was Dece Armed Fo	edent Ever in	u,S.	3. Was Dec	edent of H	lispenic Ori	gin? (Sp	ecify Yes or h	Vo- 14. Ra	ce - Ami	ericen Indian,
是 是		Married 2 Mer		1 Yes Gi	2 1 No			2 🔀 No	Specify:	, , , ,	1110011, 010.)	Specia		10, 010.
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mp	Elementary/S	Secondary (0-12)		College (1		11	e. DO NOT							
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other	20a. Method of	Disposition			20	b. Place of D	sposition (N	leme of	1		Date	20c. Location	- City or	r Town, State
7 9		2 Cremation		movel from	State	Morela	nd Mer			4/20	001	Balt	imo	re, Maryla
any injury or other to		Falperal Service		1/	11	/			ss of Facilit		-02	Dar		ic, haryre
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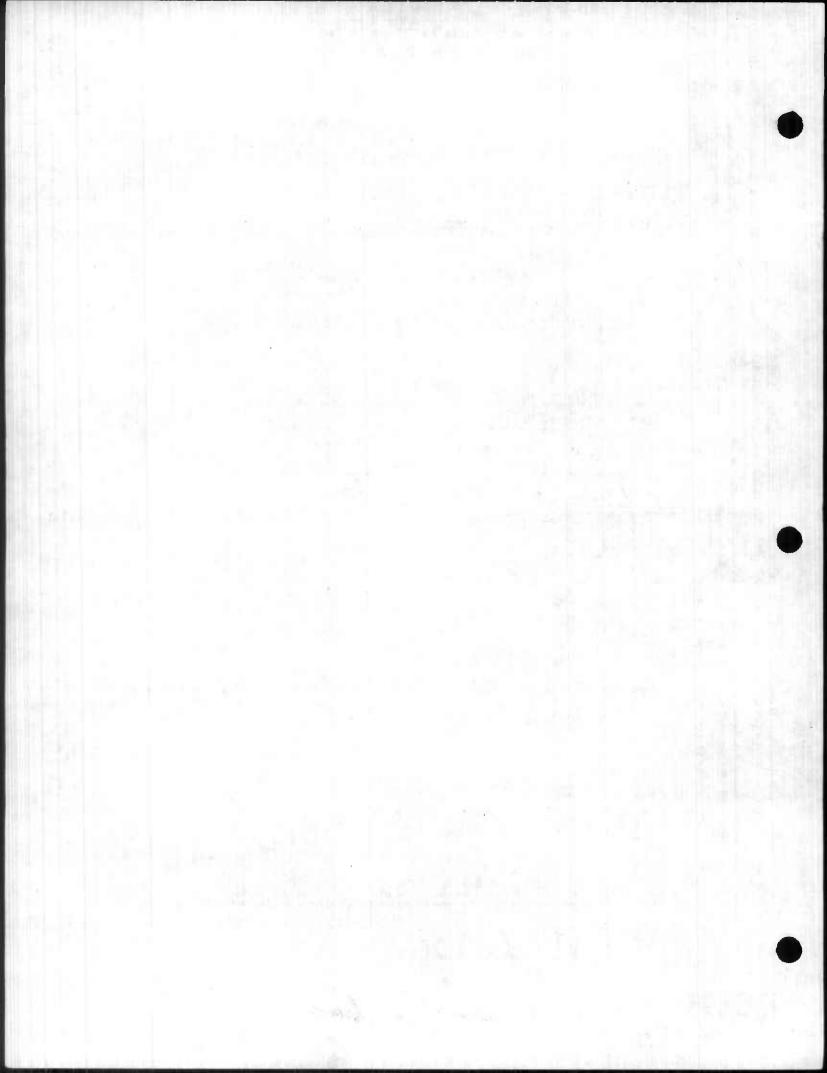
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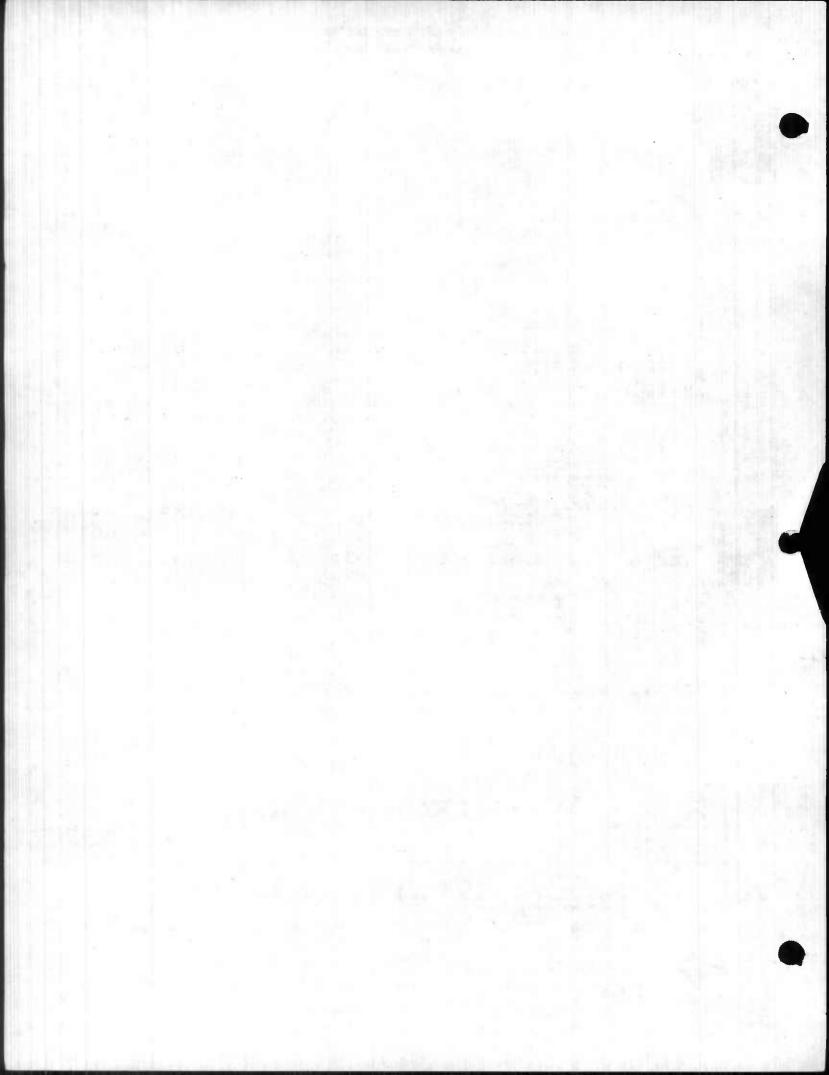
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: 25 PER PHY G791 1-10-2000 WR. Certificate of Death 2. Date of Death 2/30/2000 Month Day Yes 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** VIRGINIA H. HAMLETT DEC. 20, 2000 4:50 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner STELLA MARIS HOSPICE AT MERCY HOSPITAL BALTIMORE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 21, 1 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2\ F 78 218-14-9497 Vrs 1922 MARYLAND Director Usual Residence of Decedant 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ANNE ARUNDEL **PASADENA** Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 3906 BELLE OF GEORGIA AVE. 238 21122 UNITED STATES Funeral Barras 12. Wes Decedent Evar in U,S. Armed Forces? Place - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Specify: WHITE A 3 Nidowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SALES CLERK RETAIL Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant: If them 27 is marked oth lary or other traumatic aven Be ELMER KIRBY HAZEL LEWIS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3906 BELLE OF GEORGIA AVE., PASADENA, MD 21122 MELODY HARTMAN / DAUGHTER 20a. Method ol Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete cemetery, crematory or other place) 5 JAN. 1 Burial 2 □ Cremetion 3 □ Removel from State permit. Page Department of Important: If any injury or page. CEDAR HILL CEMETERY 4 ☐ Donetiog/) 5 ☐ Other (Specify) BROOKLYN PARK, MARYLAND 2001 Funerel Service Licensee 21. Signeture of 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 The caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a on each line. 23a. Part1. Enter the diseese, or complications, or heert failura. List only one Approximate Intervel Between Onset end Deeth **Physician** Immediate Cause (Final /Medical Hypsa BusiUE diseesa or condition resulting in deeth) Examiner Examiner 20 Janio. Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in deeth) Lest Due to (or as e consequence of): 68760 Physician/Medical Due to (or as a consequence of): 88 Box 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ sign 1 be 24b. Were autopsy lindings available prior to Completed 24a. Wes an autopsy performed? completion of ceuse of death? page 2 s has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: 8 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Ves 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After or Attending 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, lectory, office building, etc. (Specify) 2 4 Homicide 2 Hospital 24 hours a Funeral D

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29b. Signature and title of certifie

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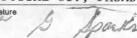
🖅 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

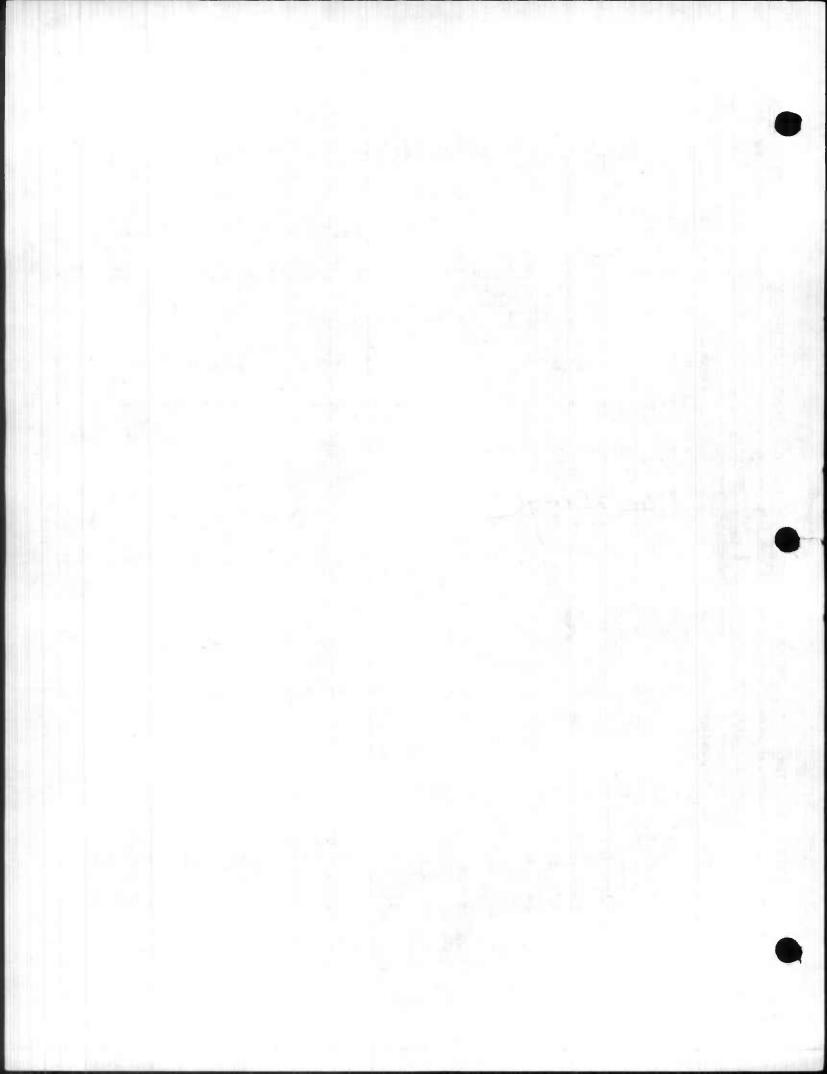
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Date signed (Month, Day, Year) JANUARY 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS C. FOLKEMER, - M.D., 4231 POSTAL CT., PASADENA, MARYLAND 21122

State Registrar 31. Date filed (Month Pay, Year) 32. Registrar's Signeture





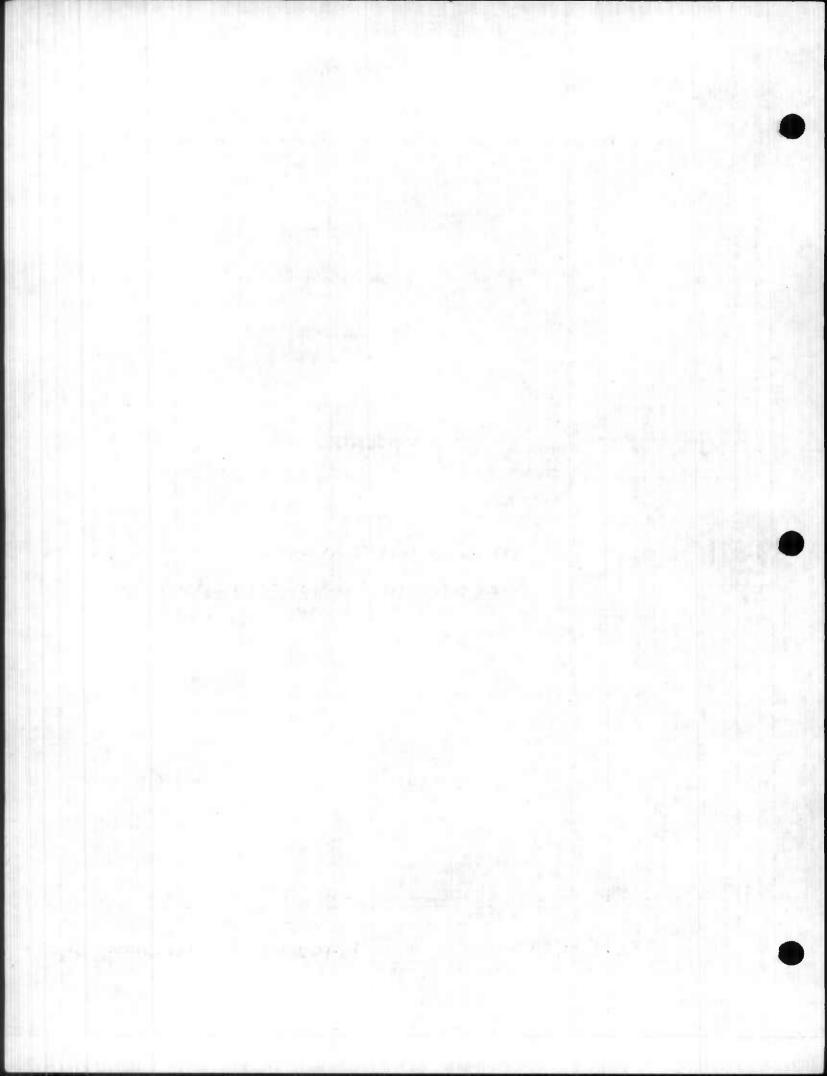
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dev 9:00 AM Month **Physician** Maude Hooker December 31,2000 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore, Maryland Baltimore Cita 1651 E. Belvedere Ave, Apt 307 If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. Nov. 15, 1920 Mary Land 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□ M 2□ F Months 80 Yrs. Director 213-03-9550 Usual Residence of Deceden 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No N/A Directo Baltimore r than "natural", or hams 23s or 21s-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 United States 1651 East Belvedere Avenue Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ♥ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If them 27 is mentaled other than "n any injury or other traumentsed other than "n College (1-4or 5+) Elementary/Secondary (0-12) Secretary Waxter Center 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Katherine Doyle Francis X. Molloy 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Anne Theresa Kelly / sister 3410 Pennsylvania St., Hyattsville, MD 20783 20b. Pleca of Disposition (Name of cametery, crematory or other pleca) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stete Chesapeake Crematory, Inc 1/3/01 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name end Address of Fecility CAFA Stephen D. Lohrmann, P.A. 21. Signeture of Funeral Service Licensee Daura Hardes/4 8717 Green Pastures DR., Towson, MD 21286 23a. Part1. Enler the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician myocardial Infarction /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) hours Examiner Atherosclerotic Cardiovascular Disease Examiner attending physician end for use es the burlai-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings aveilable prior lo 24a. Was en autopsy performed? Completed completion of cause of death? page 2 s hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certificalety filled in by the funeral director, i 25. Was case referred to medical Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) OL 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner steted. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number December 31,2000 0 04027 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Baltimore, MD 21239 5601 Loch Raven Blvd., Thomas Wilson, M.D. 31. Dele filed (Month, Dey, Year) 32. Registrer's Signeture State JAN Byer Registra

ORIGINAL

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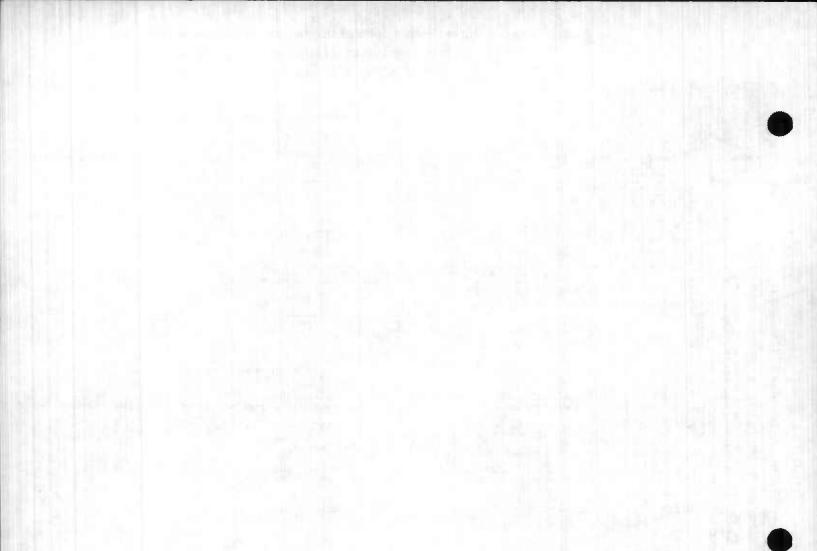


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12303

			Certificate o	f Death		g. No.		15	
Physiciar	Decedent's Name (First, Middle, Last, JANET		HOFFM	ΔΝ	2. Data of Death Month DECEMBER			of Death	
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Funeral	5. Social Security Number 6. Sec	7. Age (In yrs.			8. Date of Birth (Month, Dey,		9. Birthplace (Stete Country)	a or Foreign	
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death with the Maryland res 23s or 28s-f show Livet be notified	Usual Rasidance of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside	City Limits	
is or 28a-f show	MD BALTIMO			1 □ Ye	as XXNo				
or 28a-f	10e. Street and Number		10f. Zip Code		10	g. Citizen of W	hat Country?		
r Neme 23e or 28e-f al	8820 WALTHER BOU	LEVARD #3521		21234		U.S.A.			
Hem.	11. Marital Status	12. Was Decedent Evar In U Armed Forces?	I,S. 13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Speuban, Mexican, Puarto	ocify Yes or No- Rican, atc.)		- Amarican Indian, , White, etc.		
f, or h		1 ☐ Yes 2 No If Yes, Give Year or Dates:	1□ Yes 2Å N	lo Specify:	Specify: WHITE				
natural, or	15. Decedent's Edu	cation	16a. Decedent's Usual Occ	cupation	1	6b. Kind of Bus	siness/Industry		
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frau frau	CONSTANCE BAKER		1 BARGATE CO						
them 2	20a. Method of Disposition	20b. F	Placa of Disposition (Neme of				City or Town, State		
Important: If it any injury or once.	1 ABurial 2 Cremation 3 R 4 Donation 5 Other (Specify)	amoval from State	R SINAL CEMETE		/2/01	OWINGS	MILLS, MI	0	
y Inju	21. Signature of Funeral Servica License		22. Name and Add	tress of Facility					
any sany	Ret /	7 >	8900 RFI	STERSTOWN I			BROS., II		
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n end lel-trensit	b. Due to (or as a consequence of):								
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87 TO 99					24a. Was an	autopsy	24b. Were eutops available prid		
2 shoul					penom	led!	completion of deeth?		
page 2					1 ☐ Yes	s 20 ⁽²⁾ No	1 ☐ Yes 2	□ No	
director, pag	25. Was case referred to medical			26. Place of Death	(Check only one)			
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ther the	27. Manner of Death 1 ☑Naturel 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of 28c. In V	ljury at Vork? ☐ Yes 2 ☐ No	28d. Describe hor	w Injury occurre	ed		
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d in b	4 Homicide determined	building, etc. (Specif	(y)		City or Town,				
V fille	29a. Certifier 12 Certifying Phys		wiedge, deeth occurred et the						
within 24 hours effer death. To the Funeral Director: A completaly filled in by the funeral by	(Check only 2 Medicat Examinations)		tion and/or invastigetion, in m					8(S)	
Tota	29b. Signature and title of certifier	0	1 1	ense number			(Month, Dey, Year		
0	Wellinh	1 Mussel	D	30185	-	Decembe	431,20	0 10	
n	30. Nama and address of person who co	mpleted cause of death (Item	n 23a) (Type, Print)	30182 WALTHER	ALUD G	BATINA	OF MO	71770	
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State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	alui o	· 8					

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Registrar





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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey 2000 04 ECEMBER 20 4H City, Town, of Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) cmola 8. Dete of Birth (Month, Dey, Year) 03/28/1904 Birthplece (State or Foreign Country) WV 5. Sociel Security Number 6. Sex # Age (In yrs. last birthday) Days 1 M 2 KF Hours 98 820-03-3186 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 112 German Hill RD 21222 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 De No If Yes, Give Year or Detes: 14. Raca - American Indien, 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 □ Never Merried 2 □ Merried 1□ Yes 2No Specify 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Alex Collins Carrie Curnutte 19e. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2612 Liberty Parkway Baltimore, MD 21222 Freda Blair Daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 12/23 Elkridge, MD 4 □ Donetion 5 □ Other (Specify) Meadowridge Mem. Park 22. Name and Address of Facility Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring RD Baltimore, MD 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, any one cause on each line. 23a. Pert1. Epine shock, of he Approximate Interval Between Onset end Death Immediate Ceuse (Fine diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

physician and s the bunal-trensit law requires that the death cartificate be avacuted Division of Vital Records. P.O. Box 68760. attending p by the a 3 signed b s need should paga 2 s PA cartificata or Attending Physician: director, Be this death. Director: / within 24 hours a

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Baltimore, Maryland 21215-0036

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25. Wes cese referred to medical examiner? Naturet 2 Accident 5 Pending investigation

3 Suicide 6 Could not be 4 Homicide

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28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier Gertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner es stated.

| Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end manner steted.

29b. Signeture and title of certifie

29c. License number D51185 29d Date signed (Month, Dey, Year) 21224

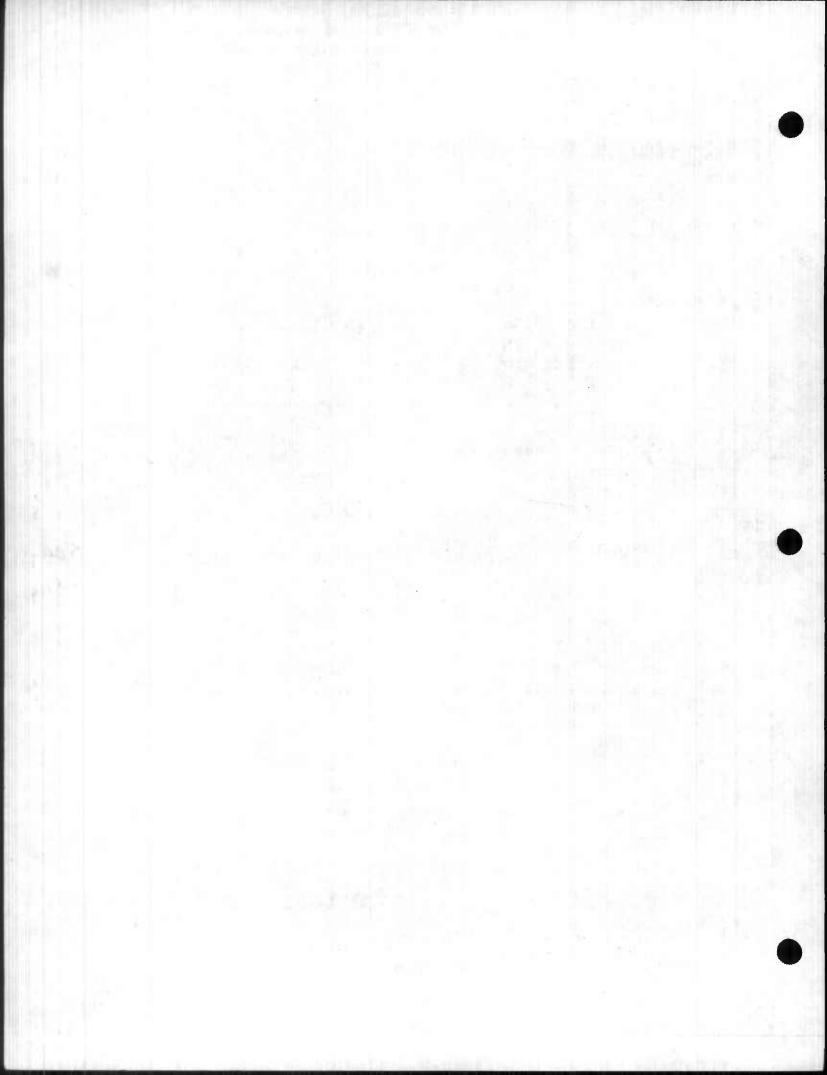
30. Name end, andress of person to completed cause of deeth (Item 23a) (Type, Print

31. Dete filed (Month, Day, Year)

32. Registrar's Signeture

State Registrar

10



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 29, 2000 WILLIAM THEODORE HOUSTON am 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death etimore Maryland General

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months Min 10M 20 F 88 Yrs. 219-07-1829 Usual Residence of Decedent 27 1912 MARYLAND 05 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ty Yes 2 No BALTIMORE CITY MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 3624 BEEHLER AVENUE 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 24☐ No
If Yes, Give **
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14 Race - American Indian Biack, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2√ No Specify: Specify: BLACK 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Cement Finisher Construction 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lydia Houston Remus Houston, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3624 Beehler Avenue, Baltimore, Maryland 21215 Ella Langford/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/3/01 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility William C. Brown Community Funeral Home 23a. Part Lefter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Bladder Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

Examine Box 68760, Physician/Medical P.O. righted by by of Vital Records, Completed Be To 륊 Certification: After Division To the Hospital or Attanding after death.

Physician

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Baltimore,

within 24 hours a To the Funeral C Medical State Registrar

27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 156 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

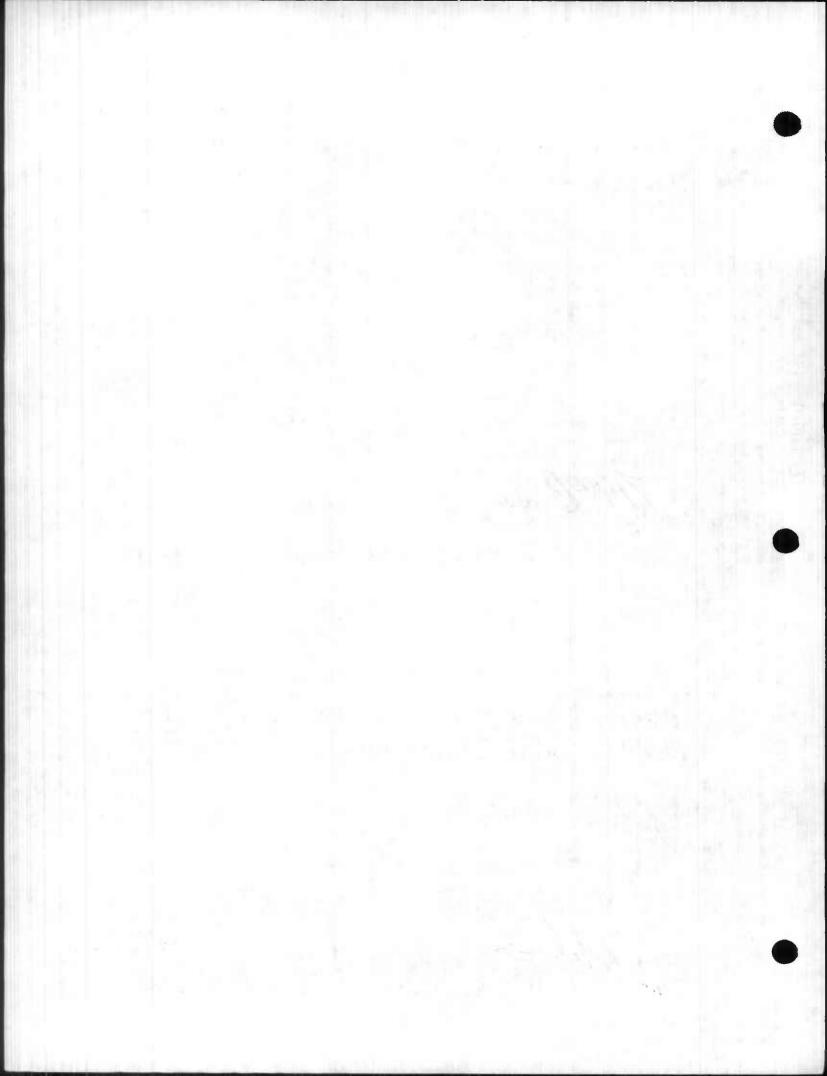
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certify 0

rsen who completed cause of death (Item 23a) (Type, Print) Haams 1600

31. Date filed (Month, Day, Year) 4 2001

32. Registrar's Signature

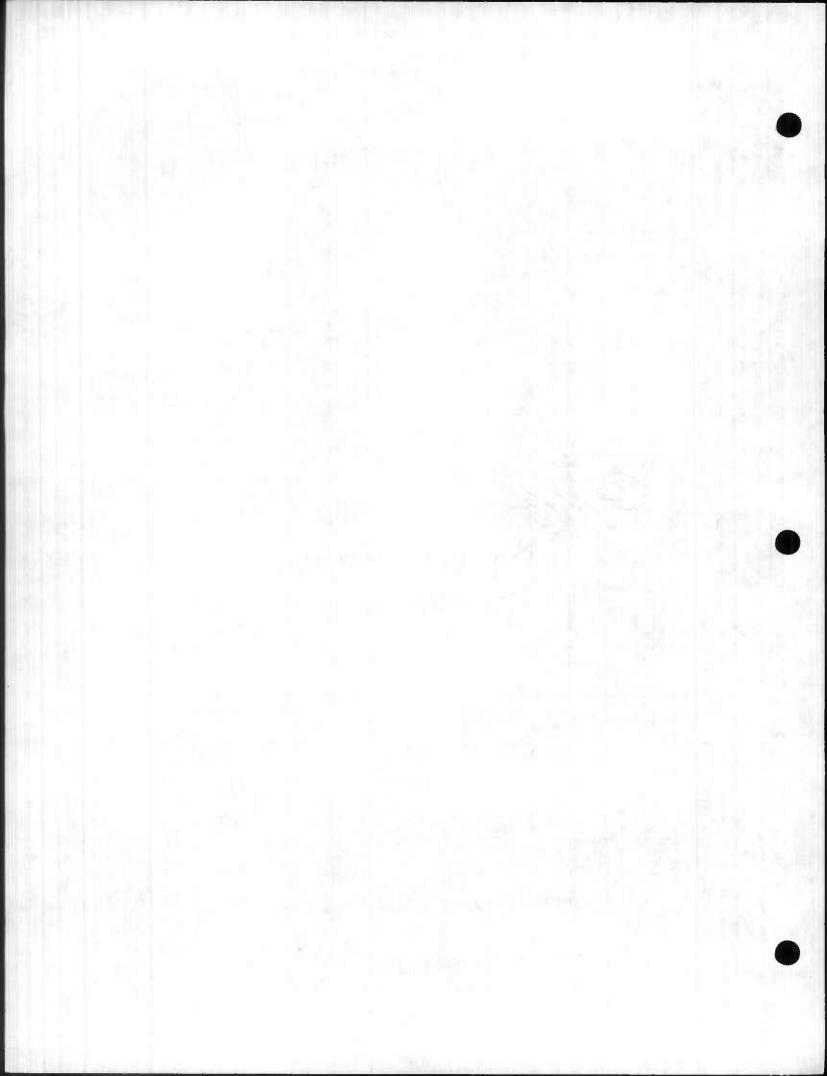
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vith the Ma t or 28a-t s be notified Director	10e. Street and Number	V V	orest Hi	10f. Zip Code		100	10g. Citizen of V	/hat Coun	try?		
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dury dury	4 Donation 5 Other (Specify)	7			ch Cem.				Maryland		
Department of the partment of	21. Signatura of Fune all Service Licensea 22. Name and Address of Facility Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206										
Physician /Medical Examiner	23a. Part1. Entar the disease or comp shock, or heert failure. List only defined the control of	Myocan		Infor					Interval Between Onset and Death		
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	1 Yes 2 No 27. Menner of Death	28a. Dete of Injury	28b. Time of	3□ DOA 28c. Inju	4 Li Nursing i	Home 5 PResi	dence 8 U0th how injury occur		W)		
leath. lor: After the funer the funer cation:	2 Accident 5 Pending investigation	(Month, Day Year)	Injury		ork?]Yes 2 ☐ No	1					
Miter of Arrect of In by	3 Suicida 6 Could not be 4 Homicide determined		28f. Location (Street and Number or Rural Route Numbar, City or Town, State)								
Hospi 24 hou Funer Hely fill		stclan: To the best of my kn ner: On the basis of examin and mannar stafad.									
within within To the comple	29th Signature and little of certifier	una maima statau.	1	29c, Licen	se number		29d. Date signe	d (Month,	Day, Year)		
F ≱ F 8	1/1/4	10		03	6430	15	1/2/	21			
	30. Name and address of person who co	ompleted cause of death (Ite	m 23a) /Tyma B	rint)				1			
4	J.M. Ric40	פא בסנקא	2	112 6	Durdalh	Sa	(timene	21	227		
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Loan	Ks						

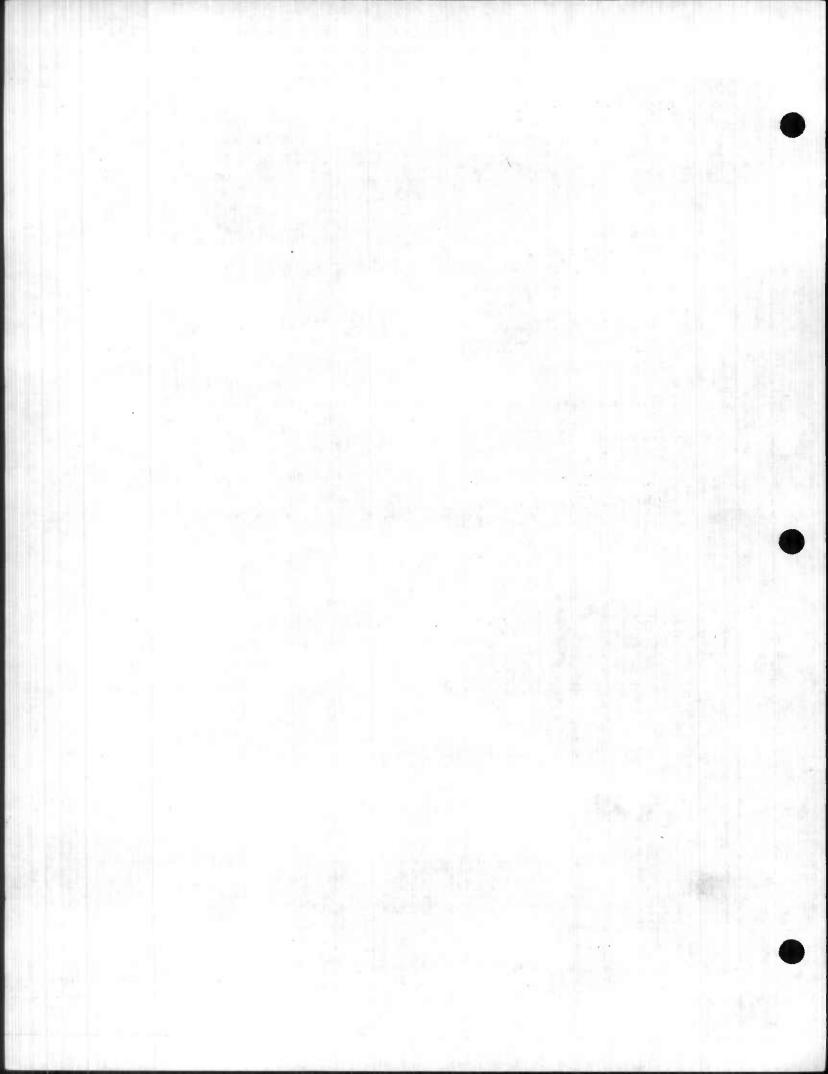
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Yee **Physician** BABY GIRL TONES 05:00 24 2000 /Medical 4s Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE MERCY MEDICAL CENTER If Under 24 Hrs. 8. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdey) If Under 1 Year Dete of Birth (Month, Dey, Year) 9. Birthplece (Ste Country) 12 23 200 Maryland Birthplece (State or Foreign Country) **Funeral** 10 M 20 F Months Deys Hours none Director Usuel Residence of Deceden the Maryland 10d. Inside City Limits 10a Stete 10b. Counts 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or flems 23s or 28s-f show traumstic event, the Medical Examinar maint be notified at Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? WITH 6331 Cragmont Road 21228 **USA** Funeral 72 hours after death 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Raca - American Indien. 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: black Baltimore, Maryland 21215-0036 P 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media page. College (1-4or 5+) Elementery/Secondary (0-12) none none none none 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Leon Jones Stephanie Jones 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Stephanie Jones/mother 6331 Cragmont Road Baltimore, MD 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetery or other plece) Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State
4 ☐ Donetion 5 ☐ Other (Specify) In State 21. Signeture of Funeral Service Licenses de 23 Name and Address of Facility Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Perti. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediete Ceuse (Finel disease or condition resulting in death) RESPIRATORY DISTRESS SYNDROME Examiner Due to (or es e consequenca of): Examiner RIGHT PNEUMOTHORAX The law requires that the death cartificate be executed attending physician and for use as the bunal-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury PREMATURITY Division of Vital Records, P.O. Box 68760. EXTREME Physician/Medical thet initieted events resulting in death) Lest Due to (or es e consequence of) 98 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. the signed by to 1□ Yes 2 No 3 Probably 4 Unknown g 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? been sign 24e. Wes en eutopsy performed? Completed ete has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Director: After this cartificeted in by the funeral director, pag Physician: Be 25. Wes case referred to medical 26. Piece of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of To the Hospital or Attending Physicial 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide edicai Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

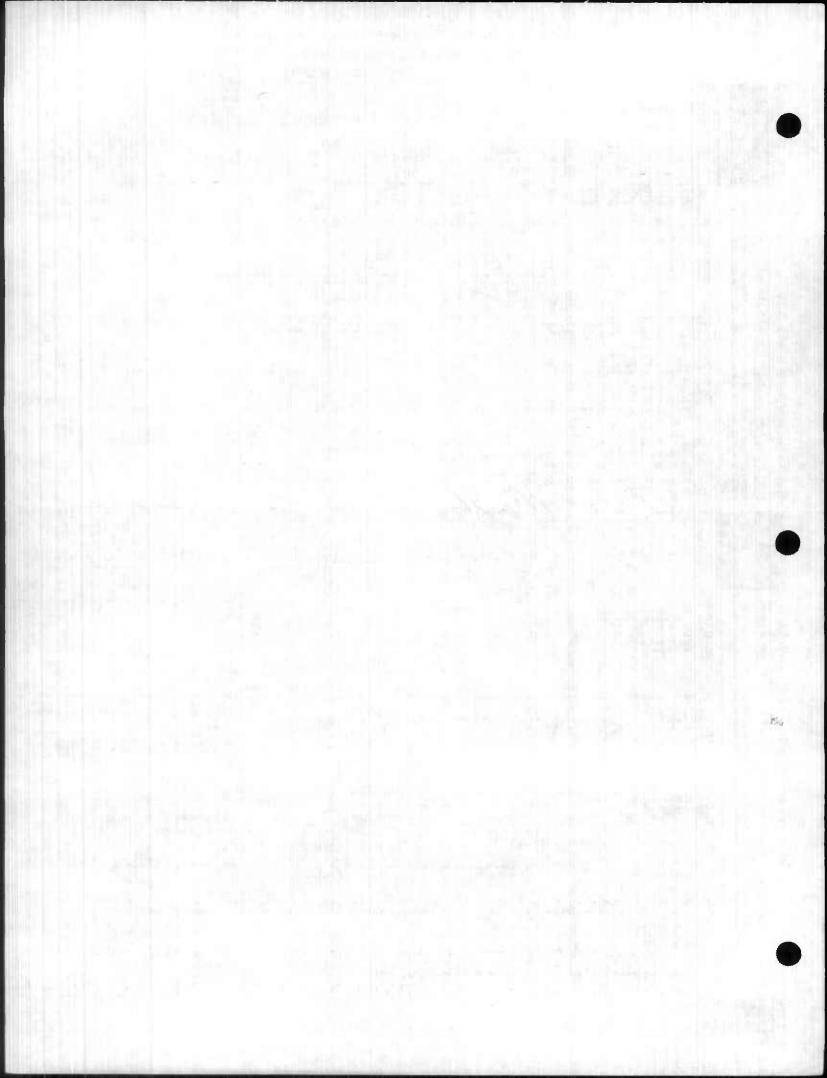
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) CHUMMUZE MD D054155 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) MUHUMUZA, MBRCY MEDICAL CTR, 301 ST PAUL PLACE, BALTIMORE CATHERINE 31. Dete filed (Month, Day, Year) parks 32. Registrer's Signeture State JAN 0 4 2001 > Registra



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Cei	rtificate of	Death		Reg. No.	JU	+2308
	1. Decedent's Name (First, Middle, Last)	BITTERS				2. Data of I Month	Death Day	Yaar	3. Time of Death
Physician /Medical	Richard ones					12	28	2000	8:00 a.m.
Examiner	4a Facility Name (If not institution, giva si	reet and number)				n, or Location of De		unty of Death	
	10 Peapod Ct				Woodla		Bal	timore	5
Funeral Director	5. Social Sacurity Number 6. Sex 103-18-7681	7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Yaar Months Days		Min. (Month, I	Birth Day, Year) 30-1927		placa (State or Foreign intry) N.Y.
2 .	Usual Residence of Decedent	100 0%	y. Town or Lo				00 1327		10d. Inside City Limits
with the Maryta a or 28a-f show be notified at Director	Md Baltimo		oodlaw						1 ☐ Yes 2 🖾 No
23a or 28a-f. at be notified	10e. Street and Number 10 Peapod Ct			101. Zip Code 21207			10g. Citizen	of What Cou	intry?
dear dear	11. Marital Status	2. Was Decedant Ever in U,	S. 13.	Was Decedent of	Hispanic Origi	n? (Specify Yas or I Puarto Rican, etc.)	No- 14.	Race - Amari	
vatural', or its sizal Examina sted by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1/1/Yes 2 No fryes, Give Year or Dates:		1 ☐ Yes 2 ☐ No		Puarto Pican, etc.)		Black, Whita, ecify: B1	lack
d within 72 hours at plens. or then "nehurel", or the Medical Exam Completed by F	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occu	pation	of working	16b. Kind o	of Business/Ir	ndustry
mple riple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retin	9d)		5 11	2	
ed within typiens. her then it, the Me	12th grade	2 years		Foreman				lehem	Steel
B vege	17. Father's Name (First, Middle, Last) Allen Jones, Sr					is Nam <i>e (First, Midd</i> ie L. Canı		name)	
Men									- 0-1-1
2 sh and te m	19a. Informent's Name/Relationship (Typ					or Rural Route Nun			
T and teath and the said the s	Linda Hinson- Daug			W. Fore	st Park	Avenue	Balti	more,	Md 21216
mit Pages 1 partment of Hi portant: if her y Injury or oth	20a. Method of Disposition 1	The Control of the Co	emetery, crei	Forest		1-4-01			ls, Md
Departi Departi Importu any Inj 2008	21. Signature of Funeral Service License	m ./	22	Name and Adde	F/H WE	est	1 + -	M 1 0	1015
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	n. Do not en	4300 Wal	bash Av	enue Ba	ltimore	, Ma Z	Approximate
Dhysisian	shock, or heert failure. List only one	ceuse on each line.				-			Interval Between Onset and Death
Physician / /Medical	Immediate Cause (Final	Metast	dia	1	C	ancino	waa		Sirmonth
Examiner	disaase or condition resulting in death) a.				7	aveive	7009	1	21X mon KV
William !		Due to (o	r as a consec	quence of):	U			1	
executed in and tel-transit	b.	Due to (e	r as a consec	augmon of):				1	
icete be executed physician and s the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D09 10 (0	as a consec	querice ory.					
fficete be ex g physician t es the buriel	Cause (Diseese or injury that initiated events	Due to (or	r as a consec	mence of):					
	resulting in death) Last	Due to (or	as a consec	juence orj.					
at the deeth certification of the attending eteched for use eteched for use Physician/M	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	ndedvina rausa o	ivan in Part I	23h. D	ld tobacco use	e contribute	to the cause of death?
	Athenosclonofic	Cardio vas		Dise			ØY08 2□1		obably 4 Unknow
2 2 2						24a. W	as an autopsy nformed?	a	Ware autopsy findings available prior to completion of causa
The lew requirements are hes been single 2 should Completed						11	□Yes 281		of death?
certificate rector. pag	25. Was case referred to filedical examiner?				26. Place	of Death (Check on	ly one)		
	1 Yes 2 No	ospital: 1 Inpatient 2 I	ER/Outpatie	nt 3 DOA	ther: 4 Nur	sing Home 5 12 A	esidence 6	Other (Spec	oify)
Attending Physic redeath. •ctor: After this by the funeral distribution: Tellication: Tellication: Tellication: Tellication redeath	27. Manner & Death 1 Deatral 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		uryat ork? ⊒Yas 2 □ N		oe how injury o	ccurred	
lal or Attending P rs efter deeth. al Director: After led in by the funer Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory, office	9		(Street and N Town, State)	lumber or Ru	ral Route Number,
Hospi 4 hou Funer lely fill	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	clan: To the best of my kno er: On the basis of examina and manner steted.	wledge, daat tion end/or in	h occurred at the vestigation, in my	time, date and opinion, deat	place, and due to the occurred at the time	he cause(s) an ne, date end pla	d manner as ace, end due	stated. to the cause(s)
within 2 To the complet	29b. Signature and title of certifier	10	4	29c. Licer	nsa number		29d. Date s	signed (Month	n, Day, Year)
F3F8	Man foull a.	Verine, 1	n.D.	DI	7872		Janu	any ch.	2001
1.11	On News and address of		00-1 7	, ,	,		0.00	1	1
> 0	30. Name and address of person who core	eune 65	69 N	Jorth	Charl	e9 St.	Bath	more	MD 2/20,
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture A	lan	No.				



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d Mantal Hygiana 1 1 2 2 0 0

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rtificate of Death	Reg. No.	
artment of Health and	Mental Hygiene	46000

1. Decedent's Name (First, Middle, La	cf)	00	rtificate	OI DI	Jairi	2. Date of D	Reg. No.		3. Time of Death
Michael A						Month	Day BER 30,	Year 2000	23:14 PM
4a Facility Neme (If not institution, giv	e street end number)			4b.	City, Town,	or Location of Dea			
SHOCK TRAUMA UNI				BA	LTIMO TUnder 24 F	RE.		1A	
5. Social Security Number 6. S	XIM 2 F	yrs. last birthday, Yrs.	Months			in. (Month, L		9. Birthpla Country	ica (State or Foreign y)
212-06-4837 Usual Residence of Decedent	16_	110.				02-	28-84	M	D
10a. State 10b. County	10c.	City, Town or L	ocation		-			100	d. tnside City Limits
MD NA	В	altimo	re						XXX Yes 2 No
10a. Street and Number			101. Zip C	ode			10g. Citizen of	What Countr	γ?
2857 W. Lanva	le Street		21	216			USA		
11. Meritel Stetus	12. Was Decedent Ever I	n U,S. 13.	Was Decede	nt of Hisp	anic Origin?	(Specify Yes or N	No- 14. Rad	ce - America	
Never Married 2☐ Merried	Armed Forces? 1 Yes **Tho If Yes, Give					erto Rican, etc.)		ck, White, et	
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1□ Yes x2	X No	Specify:		Specif	Blac	ck
15. Decedent's Ed (Specify only highest gra		16a. Dece	edent's Usual	Occupation done duri	on ing most of t	vorking	16b. Kind of B	usiness/Indu	ustry
Elementery/Secondery (0-12)	College (1-4or 5+)		e kind of work DO NOT use	retired)					
9th Grade 17. Fether's Name (First, Middle, Last)	NA	Cas	hier	1 4	9 Methods 1	Jama (Einst Midd	McDona le, Maiden Sumar		esturant
Anthony	Lindsey	401 11 1	inn Addison 1		Elair		King		Coda)
19a. tnformant's Name/Relationship (ber, City or Town		21210
Elaine Ki		b. Placa of Disp	/ W. J	Lanv	ale s	Dete	Baltimo 20c. Location	re, I	MD.
20a. Method of Disposition ★★Burial 2 ☐ Cremation 3 ☐		cemetery, cre	ematory or oth	er placa)		Dete	200. Location	- City of Tow	m, State
4 Donation 5 Other (Specific		Sacred	Heart	t Ce	meter	y 01-0	5-01 B	altir	more, MD
21. Signature of Funerat Service Licer	1500	2	2. Name and	Address	of Facility	Balti	more, M	aryla	and 21202
Meadys	Worse	1	WM.C.	Marc	h FH	1101 E	. North	Aver	nue
23a. Part1. Enter the disease, or com shock, or heert failure. List only	plications that caused the c								Approximate Interval Between
Silver Si	A.					,			IIIIOI VAI DOIMOGII
town date O (Plant	/1								Onset and Death
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Immediate Cause (Fine) disease or condition resulting in deeth)		TINE to (of as a conse		ICT					Onset and Death
disease or condition				ICT				1	Onset and Death
disease or condition resulting in deeth)	Due t		equenca of):	ICT					Onset and Death
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OCME

DECEMBER 30, 2000

30. Name and address of purpon who completed cause of death (Item 23a) (Type, Print)

JACK M. 31. Date filed (Month, Day, Year)

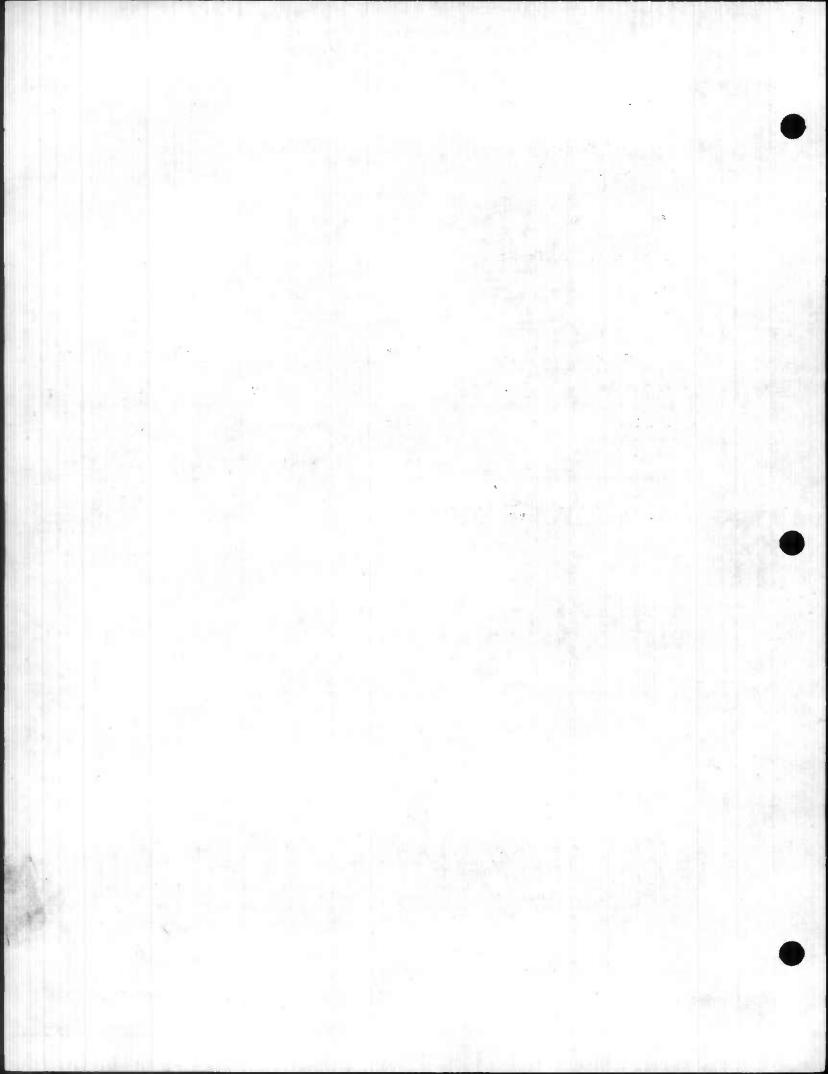
mi)

32. Registrar's Signature Penn Street, Baltimore, Maryland 21201 routes

State Registrar

JAN 0 4 2001 DHMH t6 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Vaer **Physician** VEDA LOUISE KNAPP 6100 pm December 27 200 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Union Memorial Hospital Baltimore 8. Dete of Birth (Month, Dey, Year) June 14, 1 If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Yeer Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 F Months 272-09-5877 Yrs. 1915 Pennsylvania Director Usuel Residence of Deceden the Maryland 10a Stete 10b Counts 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Harford Belair 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 124 Glenwood Road 21014 Funeral 72 hours after death 14. Race - American Indien, 12. Wes Decedent Ever in U,S.
Armed Forcas?
1 Yes 2 No
If Yes, Give
Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11, Maritel Stetus Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify Specify: White þ 3 ₩idowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) +5 teacher education 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Important: if Item 27 is marked oth
any Injury or other traumatic even Vern Leigh Greeley Roxey Alamanda Whipple 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Cynthia MacLean/daughter 1821 Eloise Lane Edgewood, MD 21040 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20e. Method of Disposition Buriel 2 Cremetion 3 Removel from State 4 Donetlon 5 □ Other (Specify) 21. Signeture of Euneral Service Licensee Royald S. Wade, Director 22. Name end Address of Fecility
State Anatomy Board 655 W. Baltimore Street Mer wee Baltimore, MD 21201 /23a. Pert1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) ardioacnic /Medical 6 days Examiner Physician/Medical Examiner certificate be asscuted attending physician and for use as the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lest P.O. Box 68760. YUJoca 0 Due to (or es e consequence of) The law requires that the death Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco was contributs to the cause of death? 1 Yes 2 No 3 Probably Unknown ate has been signed by page 2 should be detacl Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed ours after death.

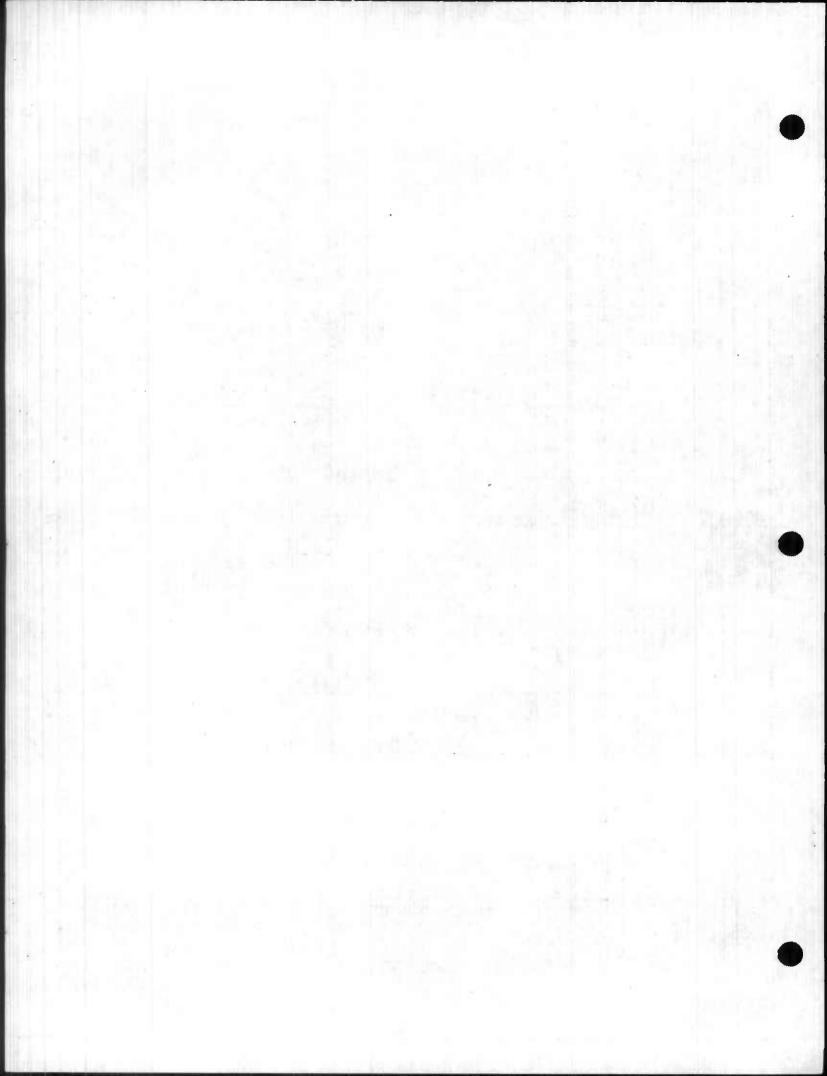
orel Director: After this certificate has filled in by the funeral director, page 2 Ma Division of Vital Physician: 25. Wes case referred to medicat examiner? Be 26. Place of Deeth (Check only one) examiner? Hospitel: Other: 4 Nursing Home P 1/2 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 8 Other (Specify) 27. Menner of Deeth 28b. Time of Injury et Work? 28d. Describe how injury occurred Certification: or Attending Naturel 20 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours att To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. edicai 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b, Signature and title of control 1) 41637 DECEMBER 28 2000 3333 N CALVERT 55 SUITE 650JPB 32 Name and address of person who completed cause of deeth (Item 23a) (Type, Print) BACTIMOR SALIM 74 31. Dete filed (Month, Dey, Year) JAN 0 4 200 32. Registrer's Signeture State ouks 04

DHMH 16 Rev 6/95

Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 1120 essue 31 2000 19 4a Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Baltimore ohns Hopkins Geriatric Center If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 05 28 9. Birthplace (State or Foreign Country) M • S • 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Months Deys 1□ M 2♥ F 491-16-9143 80 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 27 10 Columbia Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21045 U.S.A. 7038 Ivoryhand Place 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3℃Widowed 4 Divorced Black 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Restaurant Cook 12th grade na 18 Mother's Name (First Middle Maiden Sumeme) 17. Father's Name (First, Middle, Last) Isabel Burton Peter Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 7038 Ivoryhand Place, Columbia Md 21045 William Thomas-Son 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Columbia Memorial Park 1/6/01 Columbia, Md 22. Name end Address of Fecility March F/H West 21. Signature of Funeral Service Licensee 21215 23a. Pentil Enter the Disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart future. List only one cause on each line. 4300 Wabash Ave, Baltimore Md Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequenca of) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): stage renal End Due to (or as consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yas 2 100 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner Examiner

Physician

Examiner

Funeral

Director

x 28a-f show

7 is marked other than "natural", or itema 23a or traumatic event, the Medical Examiner must be

Director

Funeral

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Completed

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filed within 72 hours efter

Hygiene.

permit. Peges 1 and 2 should be file.
Department of Heaith and Mental Hyg important: If Item 27 is marked other any injury or other traumer.

Maryland 21215-0036

Baltimore,

/Medical

certificate be executed attending physician end for use as the burial-tran signed by the a d be detached f should l certificate has b director, this funeral After

Physician/Medical

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Completed

Be

To

Certification:

edical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Box 68760 P.O. Division of Vital Records. Attending deeth. the 3

Hospital or Attandi 24 hours after deeth Funeral Director: A 24 hours To the Hosp within 24 hor To the Fune completely fi

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and pleca, and due to the cause(s) end manner stated. 29b. Signature end title of certifier 29c. License number

N 69210

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 12 31

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Neme and address of parson who completed cause of deeth (Item 23a) (Type, Print)

Bayview Circle, Baltimore, MD 5505 Hopkins

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

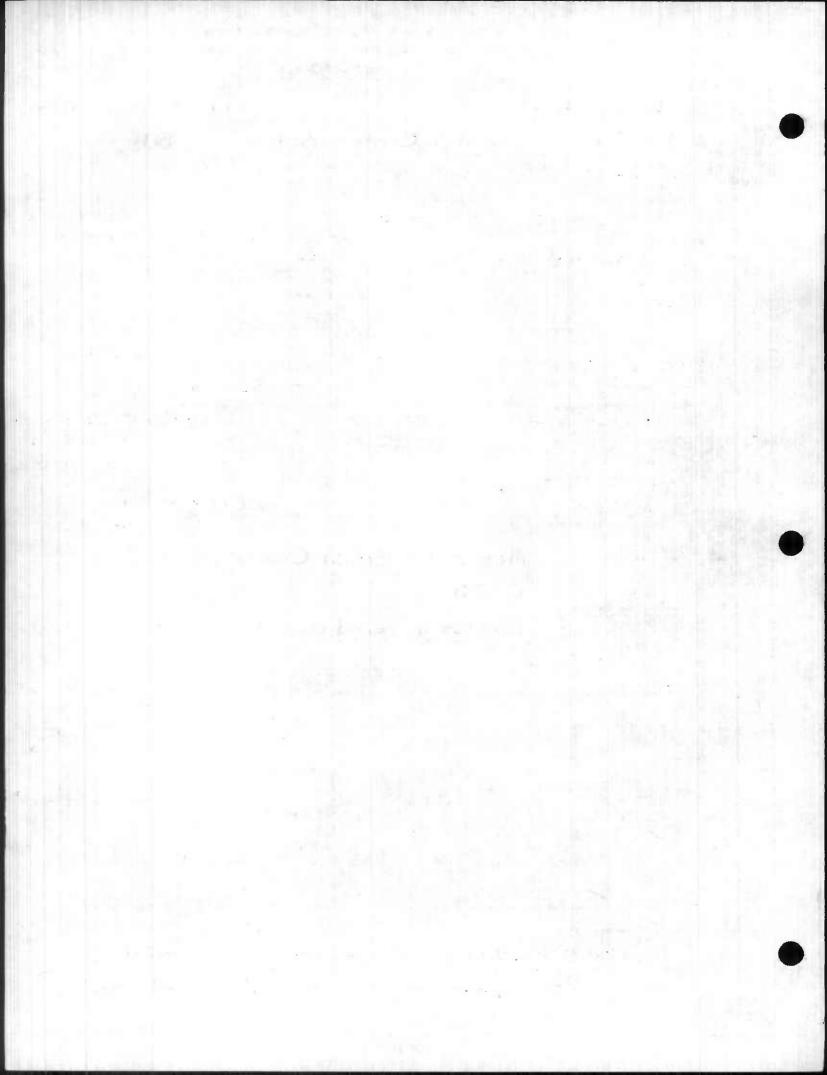
31. Dete filed (Month, Dey, Year) JAN U 4

money

5 Pending investigation

6 ☐ Could not be

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#17 perFHG791 1/4/2001 EW Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Physician **KULBAK** YEVSEY December 30 Known AS Kolbak, Yeuse /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Daltimor N/A Dalhmore 11701 6. Sex 10 M 2 F If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days WHITE 214-94-5105 Director Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits 23a or 28a-f show 1 Yas 2 No Director MD BALTIMORE BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1450 BEDFORD AVENUE #214 21208 U.S.A. Funeral 14. Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar In U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Warried 6 WHITE 1 Yas 2 No Maryland 21215-0020 Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE ELEVATOR 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Heelth and Mental Hy Important: if item 27 is marked oth any Injury or other traumatic even ables. T is mert DAVID Kul bak KUBLAK BELLA GELFAND 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1450 BEDFORD AVENUE #214 - BALTIMORE, MD 21208 SOFYA KULBAK / WIFE Saltimore. 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from State HAR SINAI CEMETERY 1/2/01 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. rocet 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical fmmediate Causa (Final disease or condition rasulting in death) Examiner Physician/Medical Examiner The lew requires that the death certificate be asscuted Sequentially fist conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants P.O. Box 68760. that initiated evants rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No of Vital Records, Be Completed by 24b. Wara autopsy findings available prior to 24a. Was an autopsy complation of cause of death? 2 No 1 ☐ Yas 2 ☐ No 1 Yas this certificate or Attending Physician: 25. Was casa rafarred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Rasidance 1 Yas 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 6 Other (Specify) 28d. Dascribe how injury occurred After Division Natural 5 Panding invastigation after death. 1 Yas 2 🗆 No 2 Accident 6 Could not be 3 Suicide 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours Hospital Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and mannar stated. within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signatura and 29c. Licansa number

State Registrar

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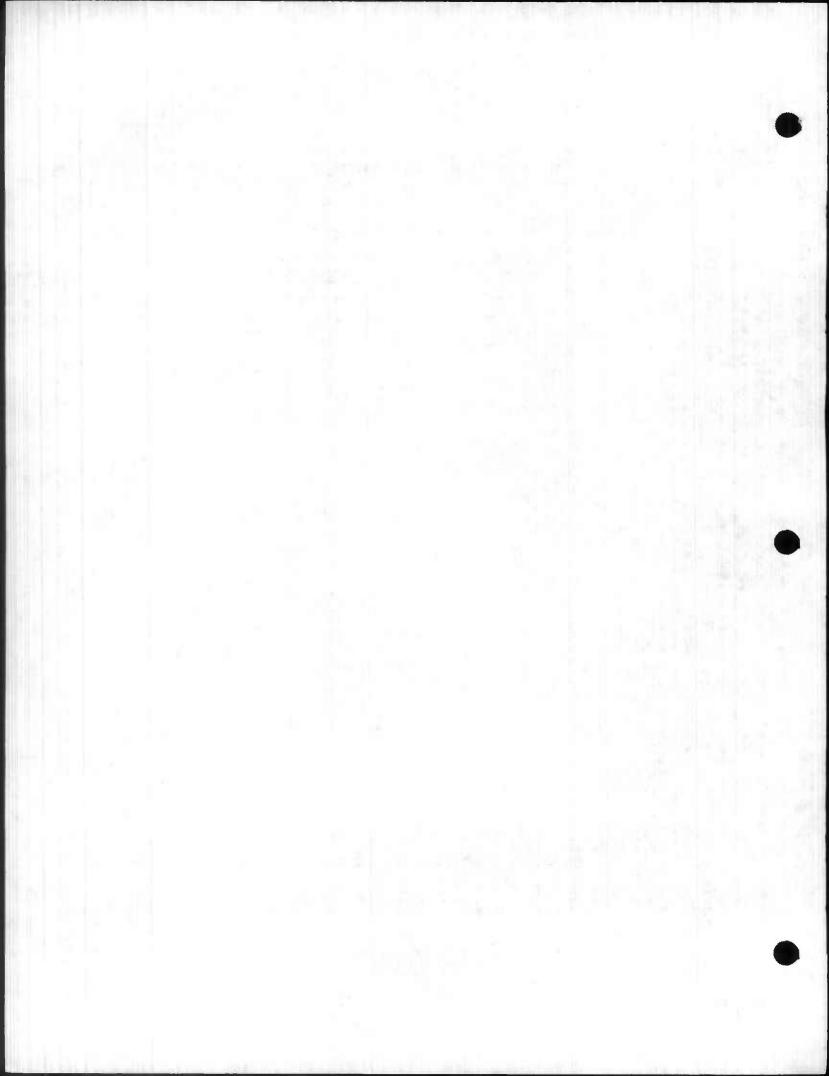
2401 West Belvedere Ave

daath (Itam 23a) (Type, Print)

32. Registrar's Signatura

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31. Data filed (Month,



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 000 Month Raymond 3/ 1245 Thomas DEC 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN Raltim DRE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/29/1918 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Deys ICKM 20 F Months Hours 82 Yrs. 217-01-6315 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4208 Raymar Avenue 21206 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 (\$\$Yes 2 □ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Status Black, White, etc. 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Sheet Metal Mechanic Coast Guard 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Peter Joseph Kelly Nellie Cassidy 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Alma Kelly/Wife 4208 Raymar Avenue Baltimore, Maryland 21206 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1⊠ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 Other (Specify) Parkwood Cemetery 1/4/01 Baltimore, Maryland 22. Name end Address of Fecility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23e. Pert1. Enter the disease, or conflications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Cardio genic Shock
Due to (or es a consequence of): disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest HLarT 1 Schemic Due to (or as a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Insufficienc 20 No 1 Yes 20 No 1 Yes 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28d. Describe how injury occurred Injury et Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not ba 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated. 29a. Certifier (Check only one)

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760 88 signed by the a d be datached f has been signed a page certificate or Attending Physician: Director: After this d in by the funeral di death. after To the Hospital within 24 hours a To the Funeral Completaly filled

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

r is marked other than "natural", or Nema 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or herr any injury or other traumatic event, in Medical Eventing 1, pages.

Physician /Medical

Physician/Medical Examiner

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with the Maryland

death

Certification: edical State Registrar

BERTONI Algin 31. Dete filed (Month, Dey, Year) 2001

29b. Signeture and title of certifier

32. Registrar's Signeture

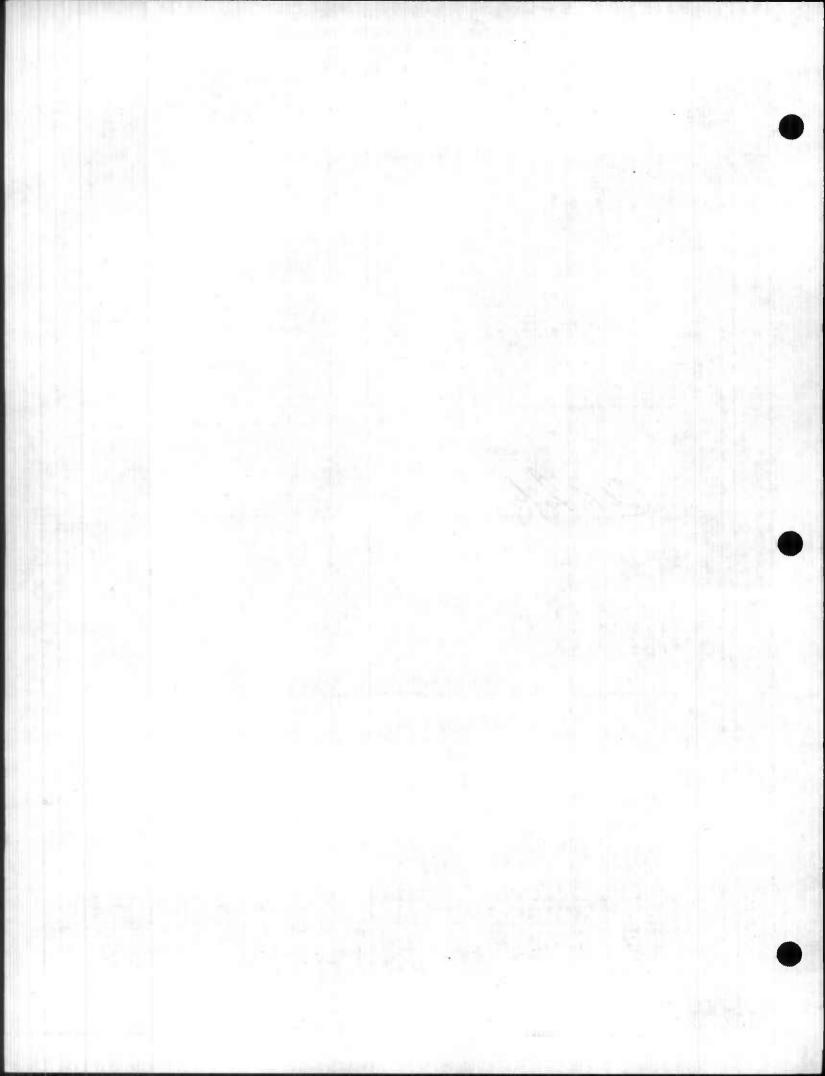
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch REVEN BIVD 13A/+imore 29d. Date signed (Month, Day, Year)

De Cember 31, 2000

29c. License number

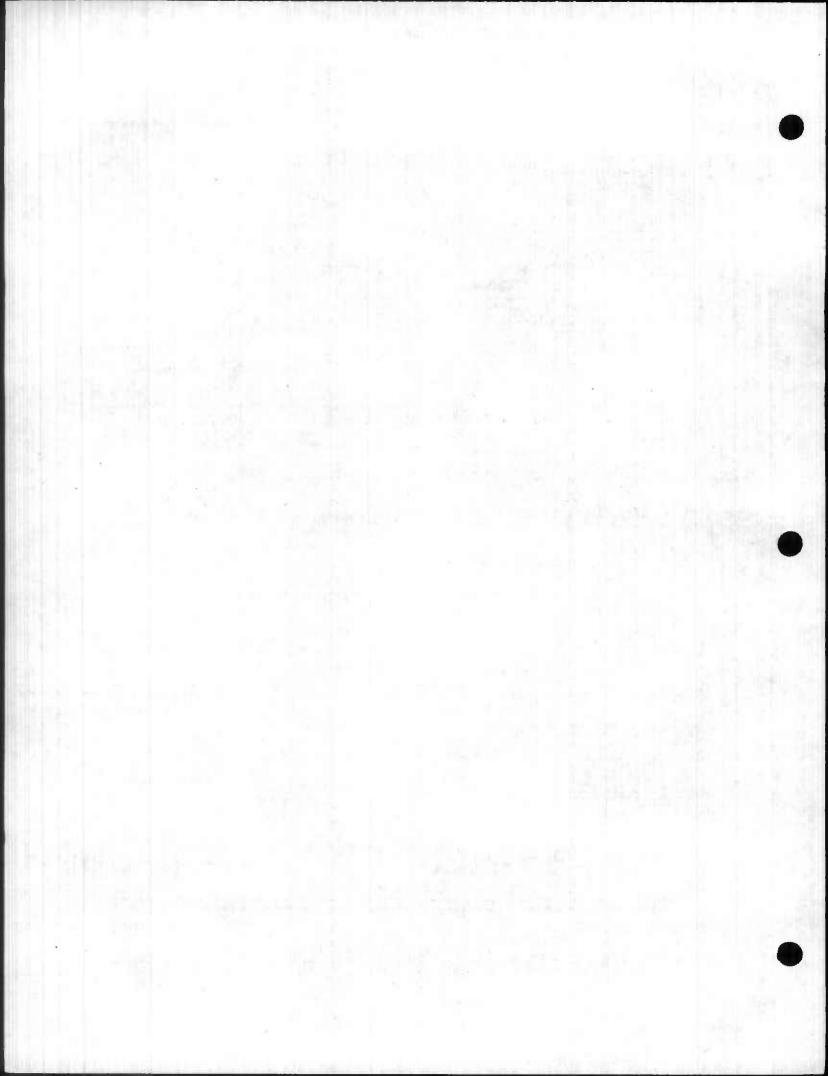
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State of Maryland / Department of Health and Mental Hygiene 00 423 14

AMENDET	ITE	M#'s 4b,4c, and 23ab pe	er phys G791 01040	Ol SCertifi	icate of	Death	2. Date of De	Reg. No.		3. Time of Death
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/Med Exam		4a Facility Neme (If not institution, give	street and number)				or Location of Deel	,		7.30 WM
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	by	3€ Widowed 4 □ Divorced	If Yas, Give Yaar or Datas:	10	Yas 20 No	Specify:		Specify:		hite
5-0 72 ho	pete	15. Decedant's Ed (Specify only highast grad		16a. Decedent'	's Usual Occup	oation during most of v d)	vorking	16b. Kind of Bu	sinass/In	dustry
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Alar 2 sh end le m		19a. informant's Name/Ralationship (7 Joseph A. Genslei					Rural Route Numl gemere, l		State, Zip 212	
Baltimore, Noemit. Peges 1 end Department of Heelth Important: If them 27 and Injury or other them 27		20e. Mathod of Disposition		lace of Dispositio	on (Nama of ory or other ple	ce)	Data	20c. Location -	City or To	own, Stata
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Baltirr pemit. Pe Department Important: any Injury		21. Signature of Prineral Service Licente	Field				l Home o			
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Division of Vita To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Certification:	(Check only 2 Medical Exam	reician: To the best of my kno iner: On the basis of axamina							
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8		30. Nema and addrass of person who of	omplated causa of daeth (Itan	1 23a) (Type, Prin					,	
0		BRUCE LEFF, MI				wew Ci	rde, But	timore . 11	10	21224
S	tate	31. Data fited (Month, Day, Year)	32. Ragistrar's Signa	tura	, /					
Regis	trar	JAN U 4	LUU Saper	19	10	arks				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Dey Month MORRIS LEVITT DECEMBER 21, 2000 6:19 AM 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death 5411 Walther Avenue Baltimore 5. Social Security Number 6. Sex 1 → M 2 → F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthpiace (State or Foreign Days Months Hours Min Yrs. 93 216-01-7901 Sept 30, 1907 Usual Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10m State Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? 5411 Walther Avenue 21214 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. unk 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working unk life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) unk Elementery/Secondary (0-12) Cotlege (1-4or 5+) unk 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Eli Levitsky Sadie Shuster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) unk unk 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, crematory or other plece) Dete 20c. Location - City or Town, Stete □ Burial 2 □ Cremetion 3 □ Removel from Stete 4 Donetion 5 □ Other (Specify) 21. Signature of Exheral Service Licentical Control of 22. Name and Address of Facility State Anatomy Board Wade, Director 655 W. Baltimore Street nen Bultimore, MD 21201 The literation of dying, such as cardiac or respiratory errest, shark, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Deeth Immediate Ceuse (Finel ACUTO MYOCARDIAL INFARCTIONS Due to (or es e consequenca of): disease or condition resulting in deeth) Chroio Vas cular Os Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown BRONCHITTS, DBPROSSION 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother Specify Atther bus 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred. 121 7214.

Physician /Medical Examiner

that the death certificate be executed

requires

Tha law

Box 68760.

Division of Vital Records, P.O.

Examiner

Physician/Medical

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Certification:

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5 Euneral Di Funeral Di letaly filled in Hospital

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marked other the "natural", or items 23s or 28s-f show imetic event, the items and items are must be notified at

with the Marylend

72 hours efter deeth

filed within 7

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If I lem 27 is marked other any injury or other treumatic event page.

Baltimore, Maryland 21215-0020

physician end s the burial-transit 9 attending Se the detached signed by t should should has a 2 page iis certificate h al or Attending Physician: T s eftar death. if Director: After this certifical After this funeral of à

Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

1 Yes 2 No 27. Meryfer of Deeth 28c. Injury et Work? 28b. Time of Injury

32. Registrer's Signeture

28e. Date of Injury (Month, Dey Year) 1 Naturel 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🗹 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end placa, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier

31. Dete filed (Month, Day, Year) 0 4 200

29c. License number

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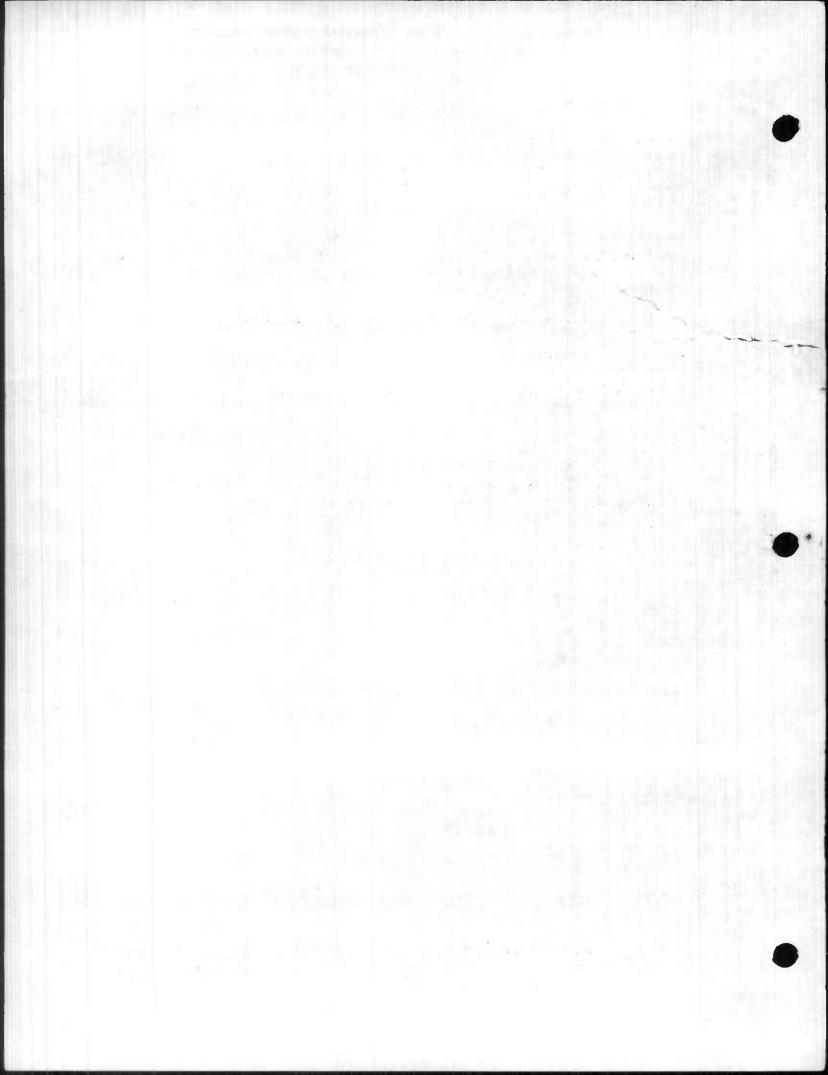
1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Yeer) 12-22-00

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 4706 HARTORD M., BOUTO, MA., 21214 DONATO A. VARGAS JE

State Registra

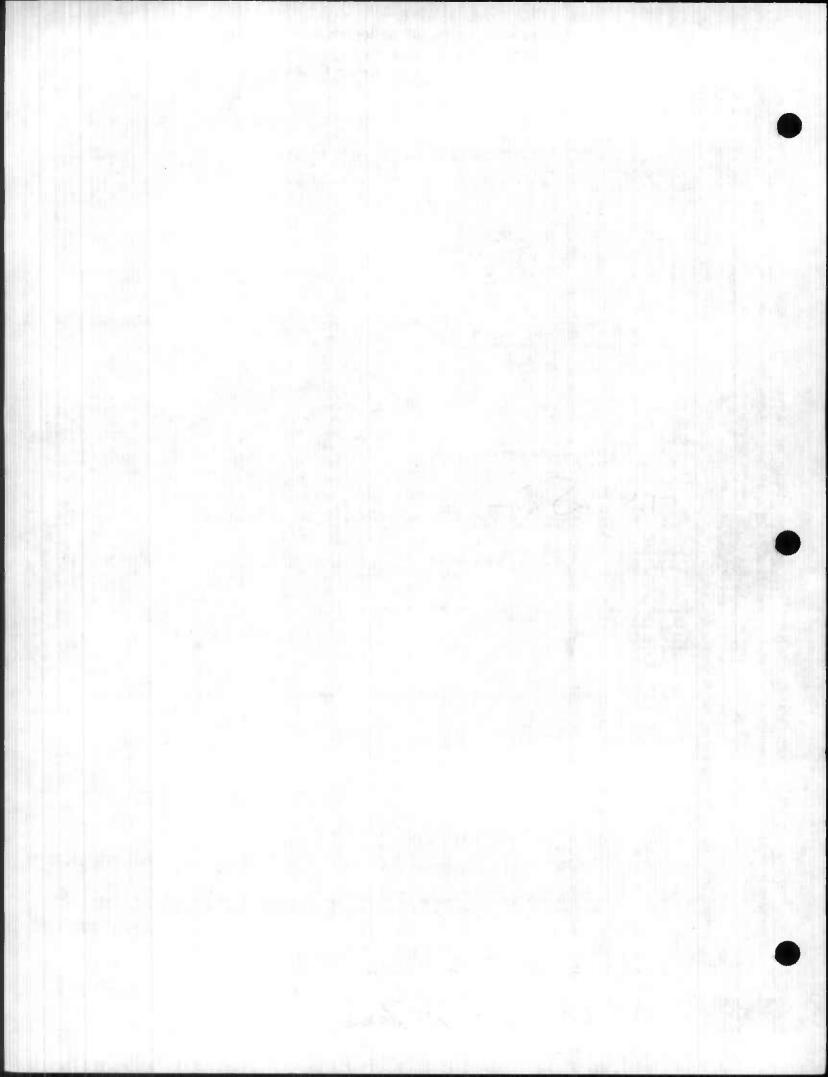
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State of Maryland / Department of Health and Mental Hygiene 00 423 | 6

			Ce	rtificate	of Death		Reg. No	0.		
D(1. Decedent's Name (First, Middle, La	st)		10, 120		2. Data of D	eath	av	Year _	Time of Death
Physician /Medical	Reuven Le	opold				Dec.	24,	^{ay} 200	0 5:	20 p.m
Examiner	4a Facility Name (If not institution, giv 10608 Willowbr	ook Drive	168		Potomad		Me	c. County	omery	
Funeral Director	5. Social Security Number 0.34-32-3086	6ax 7. Age (In yrs. 62	last birthday Yrs.	Months D	ear if Under 24 H ays Hours M		irth ay, Year D, 1	938	9. Birthpleca (Country) Romani	State or Foreign
art show affect at ctor	10a. State 10b. County MD Montgom		ty, Town or L	ocation						side City Limits ☐ Yes 2X No
death with the Maryla me 23e or 25e-f sho r.mat be notified at neral Director	10e. Street and Number 10608 Willowbr	ook Drive		10f. Zip Co 2085			10g. C		Vhat Country?	
ar, or the Examina by Fu	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in L Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas:	I,S. 13.	Was Decedent If Yes, specify 1 ☐ Yes 2 ☑	of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yas or N erto Rican, etc.)	0-		e - Amarican Inc. k, White, etc. White	
ed within 72 ho ygene. we than "natur it, the Medical. Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondery (0-12)		16a. Dece (Give life. Engi		ccupation lone during most of v etired)	vorking		Kind of Bu	siness/Industry	
	17. Father's Name (First, Middle, Last		21191	11001	18. Mothar's N	lame (First, Middle			a)	
Mental H Mental H mile avan	Edward L. Leop					a Abrah			7	
d 2 should be and the track to the track the t	19e. Informent's Name/Relationship (Dora Leopold				treet and Number or					20854
Pages 1 ar lent of Hea nti If Nem I ry or other	20a. Method of Disposition 1 Purial 2 Cremation 3 4 Donation 5 Other (Specif		cemetery, cre	osition (Name ematory or othe Vid Me	of rplace) emorial	Data 12/27			City or Town, S	
Departri Departri Importa any inju	21. Signature of Funeral Service Holl		. 2	22. Nama and A	ddress of Facility Nahway, Fa					
Physician	23a. Part1. Enter the pin ase, or com shock, or haart lilling. List only	plications that caused the dea one cause on each line.	th. Do not er	nter the mode o	f dying, such as card	liac or respiratory	arrest,		Inter	roximate val Between et and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Pancrea	tic C						mont	hs
i d		h								
cate be assected physician end s the burial-transit	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a conse	equenca of):						
5 5 5	rasulting in death) Last	Dua to (d	or as a conse	quance of):	15.0					
at the death ce d by the attendir etached for use Physician/I	Part II. Other significant conditions of	ontributing to death but not ra-	sulting in tha	underlying caus	a givan in Part I.	23b. Dio	tobacc	o uss cor	ntributs to the	csuse of death?
as that the digned by the be detached by Physical by P						10] Yes	2□ No	3 Probably	45 Unknown
aw requir						24a. Wa	s an aut formed?		available	utopsy lindings a prior to ion of cause ?
0 - 0 E						10	Yes :	2⊠ No	1 ☐ Yes	2 3 No
certificate rector, par	25. Was case referred to medical examiner?					Death (Check only	one)			
Physician: this cartific rel director. : To Be	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐				Home 5⊠ Res				
Ing Ing	27. Manner of Death 1 2 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b		28b. Time of Injury	М	Injury at Work? 1 Yes 2 No	28d. Describe				4-14
whal or Attendurs effector: / Illed in by the I	4 Homicide determined	building, etc. (Speci	(y)			City or To	own, Sta	te)	per or Rural Rou	
To the Hospital of within 24 hours of To the Funeral Discompletely filled is Medical Cel	(Check only 2 Medical Examone)	ysician: To the best of my knoniner: On the basis of examination and mannar stated.		nvestigation, In	my opinion, death or		, date a	nd place, a	and due to the	cause(s)
A Series	29b. Signature and title of certifier	h	con		5635				er 25,	
Van	30. Name and address of person who Joseph Kaplan,	completed cause of death (Ital	m 23a) (Type Prin	Print)	ilip Dr.	#327,	Oln	ey M	4D 208	32
State	31. Data filed (Month, Day, Year)	82. Registrar's Sign		1					31 -1	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Year **Physician** 8:32 PM 19 2000 Dec /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** Baltimore Lon Nursin (31 H Under 24 Hrs. 8. Data of Birth Month, Day 7. Aga (In yrs. last bythday)
Yrs. If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days -34-416 10 M 20 F Director Usual Rasidanca of Dacedanl 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mentel hygiene. 7 is marked other than "natural", or Hema 23a or 28a-f ahow treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Be permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Haalth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a and injury or other traumatic event, the Medical Example once. Funeral . Was Decedant Eyer in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cupan, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, etc. 1 Newer Marriad 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Blac Specify: Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) ashie brade 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Melvin DUIS 2 19a. Informani's Nama/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Belvedere Baltimore 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensas 3512 Frederic 21229 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final Unherry disaasa or condition rasulting in death) Examiner Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ₽thknown 1 Yes 2 No should be dat Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 20 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 2 Natural 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation ne Hospital or Attending n 24 hours after death. 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Cartifiar completaly (Check only one) within 2 To the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cont MD 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) Greene Tree Ild 112n eman

DHMH 16 Rev 6/95

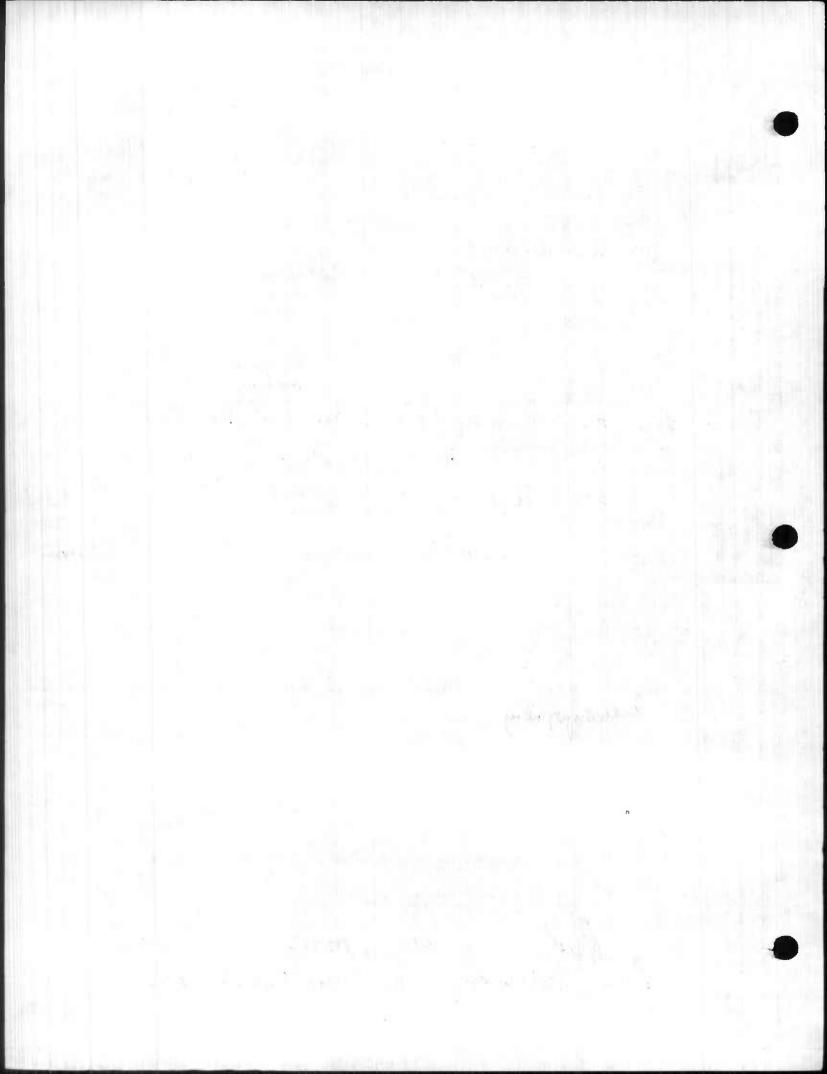
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Registrar

31. Data filed (Month, Day, Year)

JAN 0 4

32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #19a per inf G791 012201 SS 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** December 24 2000 WILBECK P. MOORE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner BATTIMORE If Under 1 Year If Under 22 Hrs. 8. Date of Birth (Month, Day, Year) CATON MANOR NURSING HOME Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 46 Yrs. FEB. 7, 1954 MD Director 214-58-8563 Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 No Directo BALTIMORE MD than "natural", or items 23s or 18s-f the Medical Examiner must be notifie NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 3330 WILKENS AVE. USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Mental Status 1 Never Married 2 Married Specify: AFRICAN 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced AMERICAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) Coltege (1-4or 5+) AUTO SERVICE 12th NA MECHANIC 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) should be nd Mental ELAINE HUGHES WILBECK F. MOORE 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important of Health an important: if Health 27 is n, any Injury or other 2005. MICHELLE Stepheny (SISTER) 1309 N. LAKEWOOD AVE BALTIMORE, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBuriel 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION CEMETERY 12/30/00 LANSDOWNE , MD 21. Signature of Funeral Samp Licenses 22. Name and Address of Fecility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217 22a. Part . Enter the disease, or complications that edused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical atherosclerotic Cardiavascular Examiner Due to (or as a consequenca ot) Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mel 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Was an autopsy Vascular disease Interet 1 ☐ Yes 2 ☐ No 1 ☐ Yes MULTI 25. Was case reterred to medical exeminer? 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

3 Suicide
4 Homicide

28e. Place of Injury - At home, farm, street, factory, offica
building, etc. (Specify)

29a. Certifier
(Check only one)

29a. Certifier
(Check only one)

29b. Signeture and title of cartitier

29c. License number

28t. Location (Street and Number or Rural Route Number, City or Town, State)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

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29b. Signeture and title of cartitier

28c. Place of Injury - At home, farm, street, factory, offica
28d. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hysician D5185

Decembe/24,2000

Michael Silvernam 900

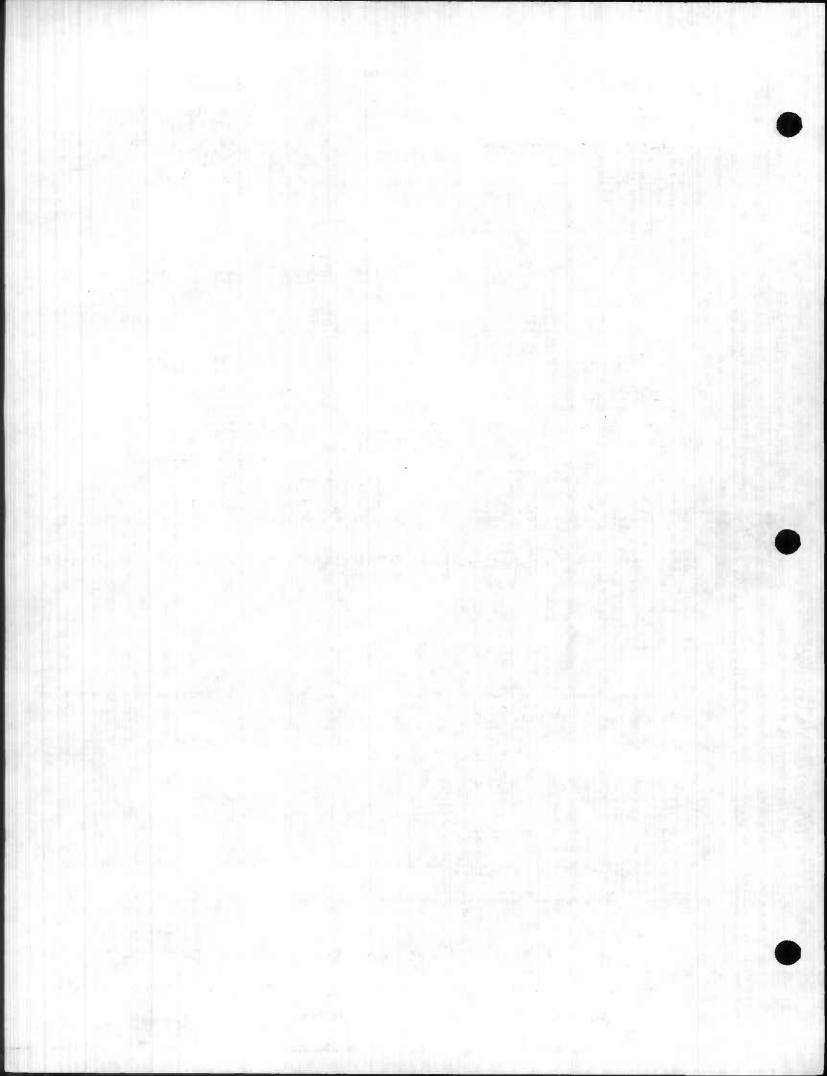
Caton Avenue baltmore 21229

State Registrar

Medical

ate 31. Dete filed (Month, Day, Year) 32. Registrer's Signature JAN 0 4 2001

B



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Moore Month **Physician** oris 2000 30 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 4121 Flintville Road Darlington If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Yrs 218-14-0143 Director 21, 1923 Maryland Usual Residence of Decedant with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD. N/A 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 417 Millington Avenue 21223 USA Funeral deeth Was Decedent of Hispenic Ongin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. Peges 1 end 2 should be filed within 72 hours efter 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give 1 Yes 2 No Specify: white Specify PV 3 ☑ Widowed 4 ☐ Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home is marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked other any Infury or other traumatic event pace. Be Henry Kittle Julia Regina Van Aelst 0 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Richard Moore - son 1124 Leonard Drive, Glen Burnie, Md. 20b. Pleca of Disposition (Name of cematery, crematory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stele $^{1/_{02/_{01}}}$ Violetville, Md. Paul Lutheran Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) St. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. maus 7250 Washington Blvd., Elkridge, Md. 21075 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsel end Death **Physician** Advanced Non-small Cell Lung Cancer /Medical Immediate Ceuse (Final diseese or condition rasulting in deeth) Examiner Physician/Medical Examiner physicien and s the burial-transit thet the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequance of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? been signed by the should be detech 3 Probably 4 Onknown 1 Yes 2 No g The law requires 24b. Were autopsy findings aveilable prior to Completed 24a. Wes en eutopsy performed? completion of ceuse of deeth? 1 Yes 2 No certificate Attending Physician: director, Be 25. Was case referred to medical examiner? aguanters 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No USE Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28d. Dascribe how injury occurred 27. Mennar of Death 28c. Injury et Work? 28b. Time of 28e. Deta of Injury (Month, Day Year) After 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be datamined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 29a. Certifier

P.O. Box 68760, Division of Vital Records.

altimore. Maryland 21215-0020

Certifying Physician: To the best of my knowledga, daath occurred at tha tima, date end plece, end dua to tha cause(s) end menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end pleca, and dua to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and tiple

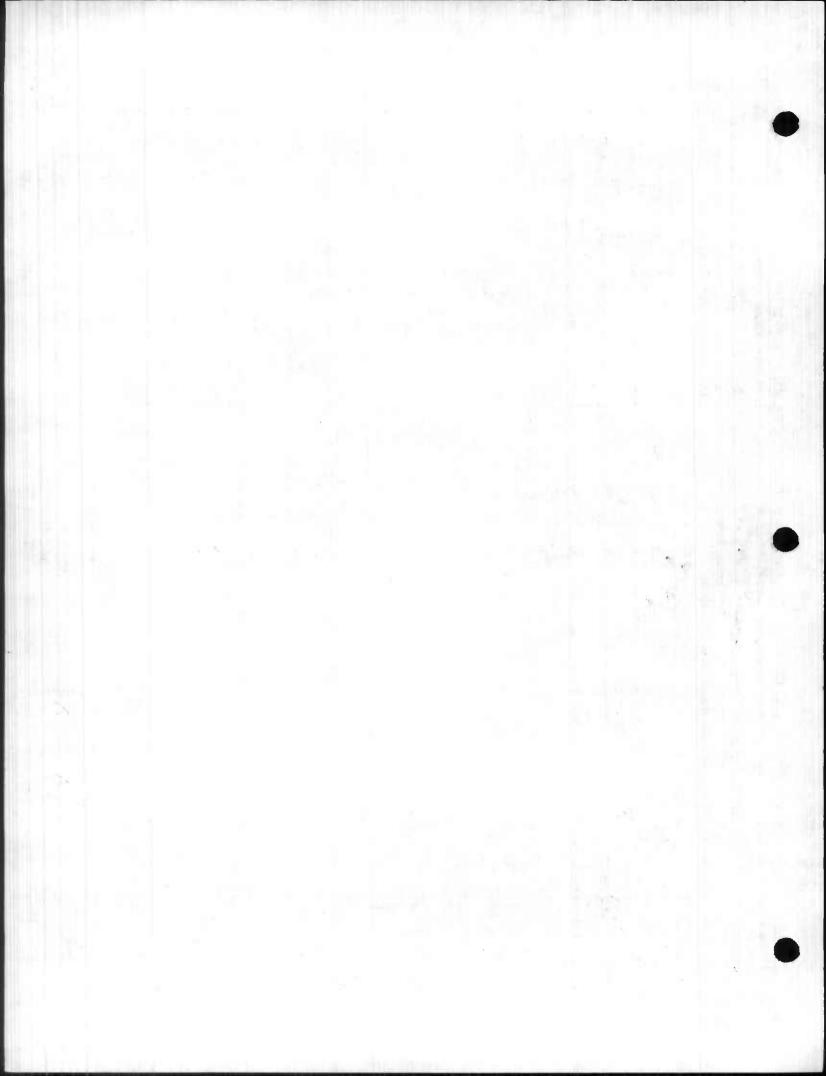
led (Month, Day, Year)

(Item 23a) (Type, Print)

32. Aegistrar's Signature

DOURS

State Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

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ysician Medical	Ü	CHARLES		A		ŀ	100RE		SR			2/2000	Year	1:05 PM
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ctor	tle	460-12- uel Residence		1 X M 2	O F	78	Yrs.	WOTERS	Days	Tiodis Will.	6/19/2	22	TEXAS"	TONIEI,
rector	_	a. State	10b. County				Town or Lo	cation					10d.	Inside City Limits
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by Funeral Director		. Marital Status		12. Wa	as Decedent med Forces Yes 2 / Yes, Give par or Detes:	t Ever in U,S .?] No ARMY :		Was Deced f Yes, spec		spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	Blac	e - American ck, White, etc. BLACK	
eted		(Spe	15. Deceder	nt's Education	oleted)		16a. Deced	ient's Usue	el Occupi	ation furing most of wo	rking	16b. Kind of B	usiness/Indus	try
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BUCS	21	Signature of	Funeral Service	Ligansee	101	14	. 22	. Name an	d Addres	s of Facility	OHN T.	RHINES C	0., IN	ic.
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DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#1,23a perPHYG791 1/4/2001 EW Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day WAYNETMISKELLY **Physician** Wayne T. Miskelly 16:10 pm 12 2000 December /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number Baltinore Mary lanel of 8. Data of Birth (Month, Day, Year 05/28/1949 If Under 1 Yaar If Under 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M 2□ F Months Hours Min. 215-48-3927 51 Maryland Director Usual Rasidance of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itama 23a or 23a-f ahow traumatic event, the Mexical Examinar must be notified at 1 ☐ Yas 2 No Directo Howard Ellicott City 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with 1 Department of Health and Mental Hydiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Evantion must be an once. USA 3487 Walker Drive 21042 Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian Black, Whita, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yas 2XXNo Specify: Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Communications 5+ Sales 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middla, Last) Theresa A. Reilly Bernard V. Miskelly 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Rita S. Miskelly / wife 3487 Walker Drive; Ellicott City, MD 21042 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 KBurial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16/00 Brooklyn, MD Holy Cross Cemetery 22. Nama and Addrass of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home Inc. 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one gauge on each line. Approximata Intervel Between Onsat end Death Physician Immediata Causa (Final disease or condition resulting in death) /Medical Brain Anoxic ⊂xami.ier Dua to (or as a consaquanca of): Examine OF BLOOD COLTS 450iration attending physician end for use as the bunal-transit The law requires that the death certificete be executed Sequantially list conditions, if any, laeding to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Henor hasic Muc Dua to (or as a consequence of) Mucositis Physician/Medical USB as t Auti Myelogeras signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s certificata has 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical axaminer? Be 26. Place of Deeth (Check only ona) To Hospital: Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1

Inpatiant 2 □ ER/Outpatient 3 □ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28d. Dascribe how injury occurred 27. Mannar of Deeth 28c. Injury at Work? Certification: 1 Natural 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, straat, fectory, office building, atc. (Specify) 4 Homicida

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, I

29b. Signatura and titla of certifiar

31. Data filed (Month, Day, Year)

29c. Licansa number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signad (Month, Day, Year)

P14666

December 12,2000

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

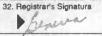
University of Maryland 22 South Green Street

Baltimore, Maryland 21201

State Registrar

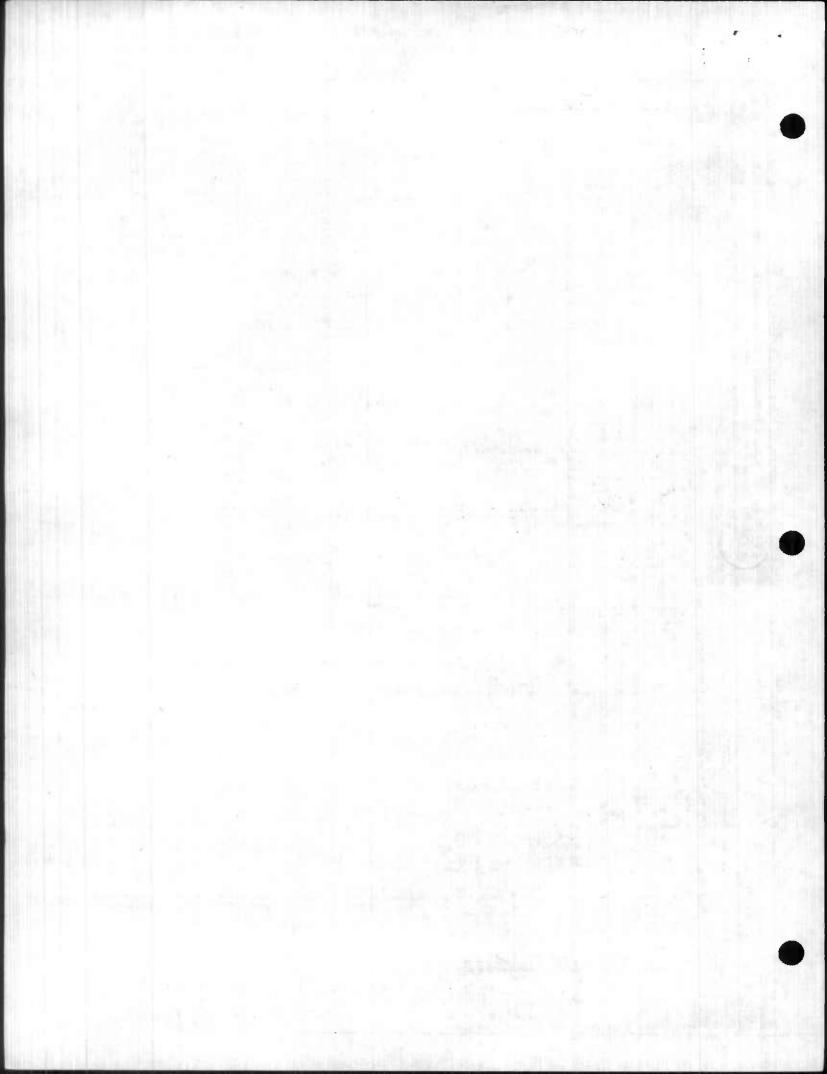
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29a. Cartifiar



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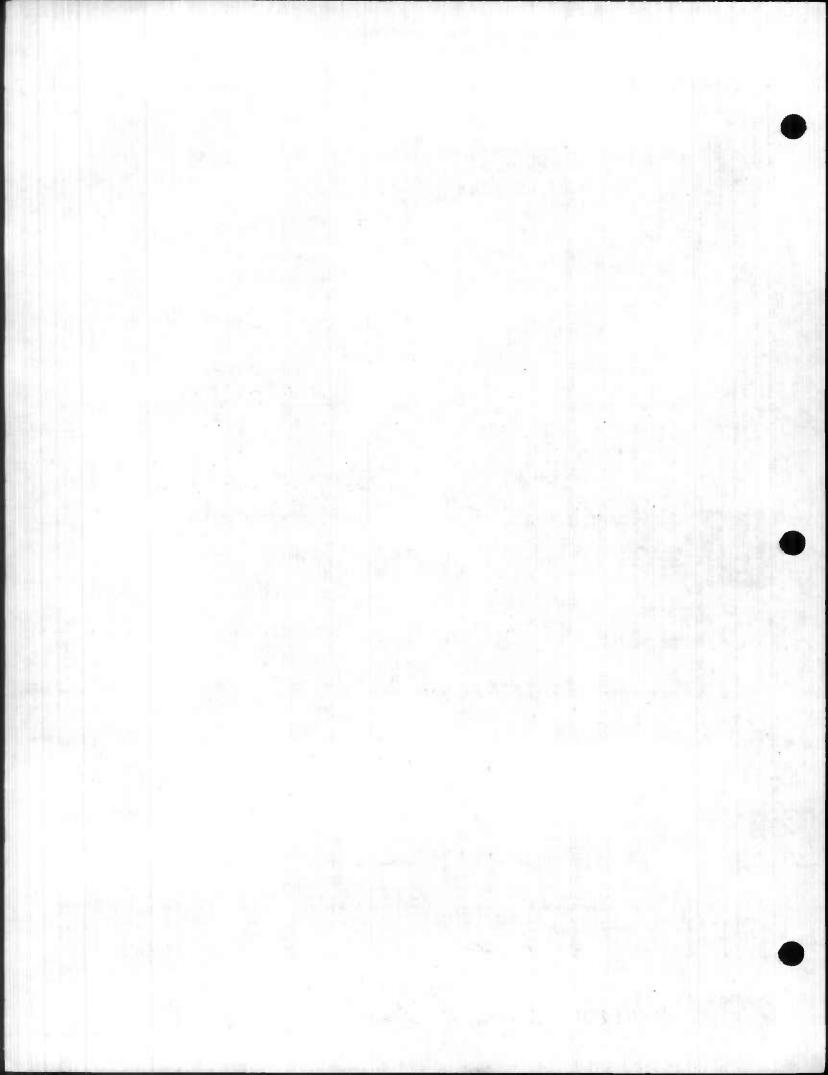
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Director	218-32-0114 Usual Residence of Decedent		reet # 7. Age (In yrs.		av) If Under 1 Yea	Baltin r If Under 24 Hrs.			N/A 9 Rirthr	place (State or Foreign			
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ā	MARYLAND N/A			BAI	LTIMORE C								
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9	15. Decedent's	Education		16a. De	cedent's Usual Occ	upation e during most of wor red)	dring	16b. Kind of Bi	usiness/In	dustry			
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17 80	17. Father's Name (First, Middle, La	51)				and the second second		Majuen Sumen	10)				
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	19e. Intorment's Neme/Reletionship					et end Number or Ru							
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K	WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE Approximete shock, or heart failure. List only one ceuse on each line. Approximete Intervel Beh												
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edical Certification: T	27. Manner of Death 1 2Nature 5 Pending 2 Accident investigat 3 Suicide 6 Could no determine	28e. Dete o (Month	jury at ork? □ Yes 2 □ No	28d. Describe h	now injury occur	red	ral Route Number,						
dical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Phyeiclan: To the aminer: On the ba	sis of examina	owledge, de tion end/o	eeth occurred et the r investigation, in my	time, dete end plece opinion, death occu	e, end due to the curred et the time, o	cause(s) and m dete end place,	anner es s and due t	stated. to the cause(s)			
	29b. Signature and title of certifier		29c. Lice	29c. Licensa number 29d. Date signed (Month, E			Dey, Year)						
) ()/	M. 7	1		0	C.M.E.		Dec	ember	31, 2000			
:	30. Neme and eddress of person who		e of death (Itan		pe, Print)	Baltimore,	Marrila			JI, 2000			

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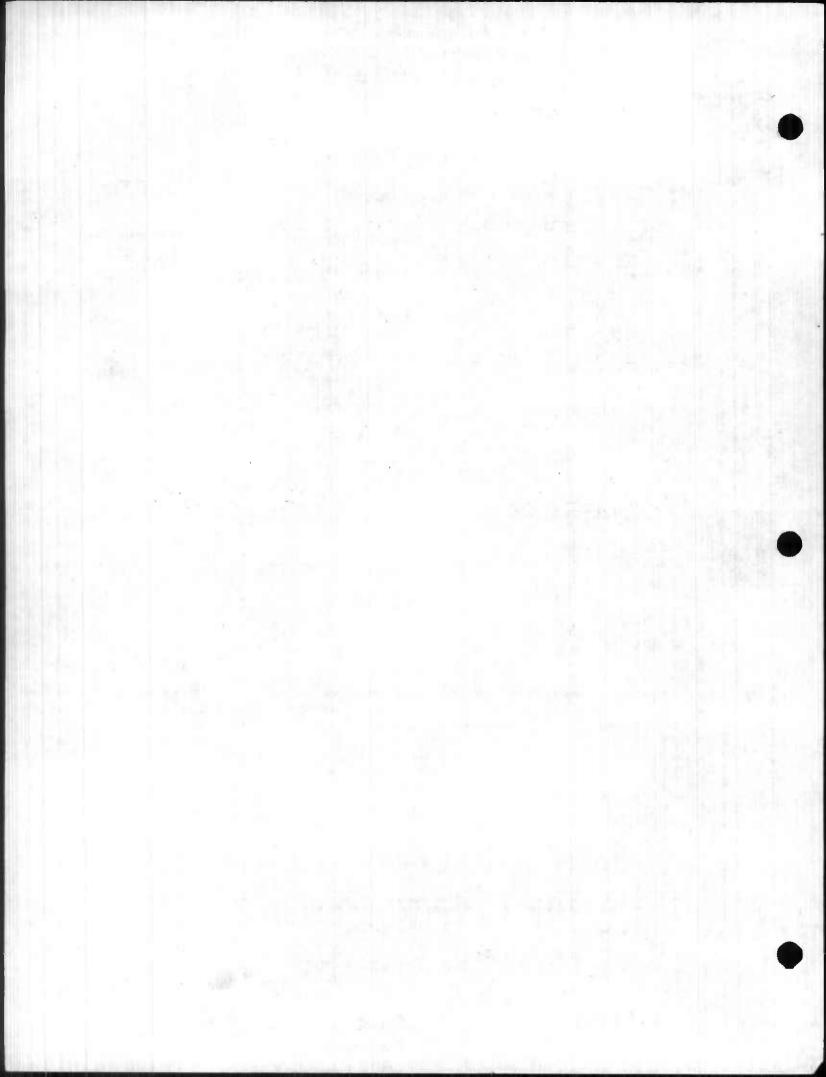
State Registrar

32. Registrar's Stgnatura

JACK M. TINS, MID.

31. Data filed (Month, Day, Year) | 32. Re

SPORTS ORIGINAL

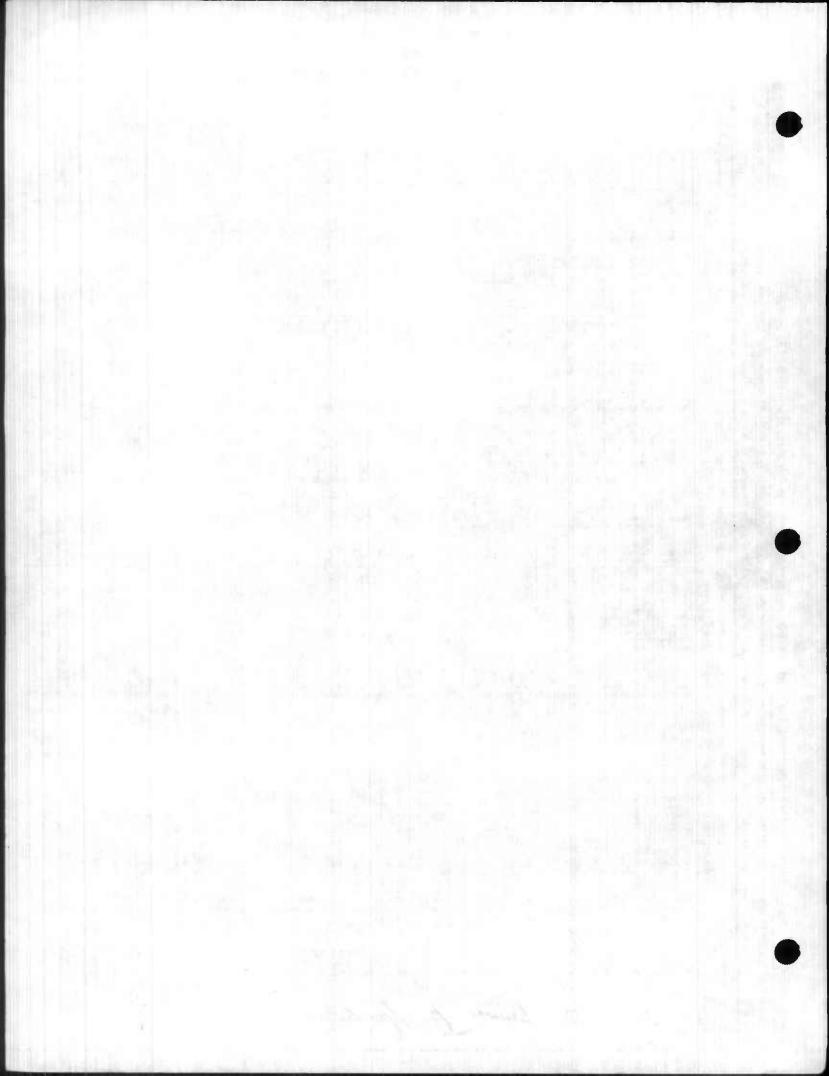


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State of Maryland

/ Department of Health and Mo		4232
Certificate of Death	Reg. No.	7606

			Cen	tificate o	f Death		Reg. No.		
	1. Decedent's Name (First, Middle, Li	ist)				2. Dete of D		Wasa	3. Time of Death
Physician	Alissa Deian	Matthews				Novem	Dey	Yeer 2000	4:00 a.
/Medical Examiner	4e Fecility Name (If not institution, gi			2011	4b. City, Town, or				1.00 4.
Examiner	Sinai Hospita		ore		Baltim	ore Ci	+ 17		
			. last birthday)	If Under 1 Ye				9. Birthol	ace (Stete or Foreign
Funeral		1DM 200F	Yrs.	Months Dey				Count	lry)
Director	N/A Usual Residence of Decedent				1 24	Novem	ber 9,4	000	Maryland
Dua E	10a. Stete 10b. County	10c. C	ity, Town or Loc	ation				10	d. Inside City Limits
Aary or			Dalais		2 4				1⊠Yes 2□No
72 hours after deeth with the Maryland natural, or floms 23s or 28s-f show one Example: must be notified at each by Funeral Director	Maryland 10e. Street and Number		Baltin	10f. Zip Code			10g. Citizen of V	What Count	200
sth with the Marylar 23a or 28a-f show tall be notified at	10e. Street and Number			Tor. Zip Code			Tog. Citizen of V	THE COURT	try r
rai	4602 Maine Av	_			215		USA		
r itama 234	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J,S. 13. W	As Decedent of Yes, specify C	of Hispanic Origin? (uban, Mexican, Pue	Specify Yes or North Rican, etc.)	lo- 14. Hace Blac	e - America k, White, e	
A PO IT	1 ☑ Never Married 2 ☐ Merried	1 ☐ Yes 2 📉 No If Yes, Give	1	☐ Yes 251 N	lo Specify:		Specify	·:	Section 1
"natural", o	3 Widowed 4 Divorced	Yeer or Dates:		100				Bla	ck
ygiene. or than "natur t, me wedeel Completed	15. Decedent's E (Specify only highest gr		16a. Decede	ent's Usuel Occ	cupetion ne during most of wo	orkina	16b. Kind of Bu	siness/Ind	lustry
than the key	Elementery/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use ret	ired)				
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工艺是	17. Father's Neme (First, Middle, Las)			18. Mother's Ne	me (First, Middl	le, Meiden Sumem	10)	
arked caveries	Roger Flynn Bl	un t			Marissa	Diana	Clark		
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tam 27 other tr	20e. Method of Disposition		Plece of Dispos			Date Date	20c. Location -		wn. State
2 2 2	1 ☐ Buriel 2 K Cremetion 3 [Removal from Stete	cemetery, crem	etory or other p	olece)				
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Department Important: I any injury o once.	21. Signeture of Funerel Service Lice	nsgisposai			dress of Facility		-	l of	Balto.
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	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury							1	
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M 3- M	VA	_		D1	3243		Novemb	er q	2000
	20 Name and address of account	completed course of death (the	m 22c) (T f			0 2 2 2 2	1	GI 9	, 2000
	30. Name and address of person who						M.D.		
	Sinai Hospital	2401 W. Be		Le Ave	. Balto	· , MD .	21215		
State	31. Dete filed (Month, Day, Year)	32. Registrer's Sign	netur	book	,				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Physician 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Don't 4a Facility Name (If not institution, give street end number) **Examiner** more 5. Social Security Number 218-18-45 If Undar 24 Hrs. 6. Sex yrs. last birthday) **Funeral** Deys 10M 20 F Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo mor arviana 23a or 28a-t the Medical Examiner must be notifi-10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 625 OY Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indien Black, White, etc. 11. Maritel Status 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Never Married 2 Merried 1 Yes 2 No 3 Nidowed 4 Divorced Hrican Hmerican Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SICI 0 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fethar's Nama (First, Middle, Last) Be 19a. Informent's Name/Relationship (Type, Print) (daughter) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) of of Health: aul Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of Date 20c. Location - City or Town, State Pages cematery, crametory or other place. 1. Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 2001 rownsville Veterans Lem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Litensee era Ave Enter tha diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrast, or heart fellure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Finel mes disease or condition resulting in death) Examiner Due to (or es e consequence of): Physician/Medical Examiner alerension Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas coptribute to the causa of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown 2 Division of Vital Records, Be Completed by 24a. Was en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 20 No 1 Yes 2 No ial or Attending Physician: These after death.

In Director: After this certificate ed in by the funeral director, pa 25. Was casa referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpetient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menner of Deeth 28c. 28d. Describe how injury occurred 28b. Time of Injury et Work? 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 29e. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Deta signad (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number 30 2000 who completed causa of deeth (Item 23e) (Type, Print) are e lugdere

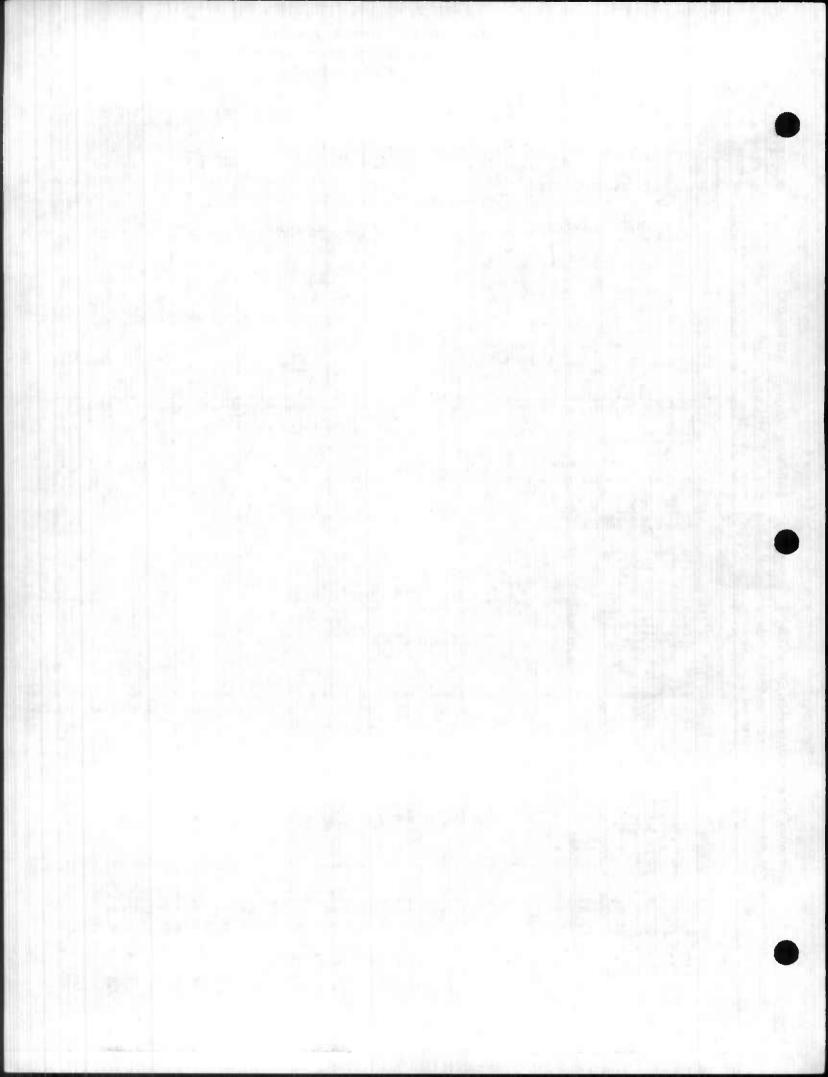
DHMH 16 Rev 6/95

Registrar

31. Date filed (Month,

JAN

32 Registrer's Signe



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Otto Arlene L. 9:40 AM 31 2000)ec 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street and number 4c. County of Death Air AIR Hartord Health Del If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) May 19, 1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Deys Country) Michigan 1 □ M 21 F Months 219-10-9900 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Harford Joppatowne 1 ☐ Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21085 United States 306 Barksdale Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Yes 2½ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 No Specify: 3√ Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Marian Ellsworth Herbert Livermore 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Leslee J. Hawkins (Daughter) 306 Barksdale Road Joppatowne, Maryland 21085 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Hilltop Service Corp. 1/4/2001 Towson, Maryland ♣ □ Donation 5 □ Other (Specify) 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a Part1 Englished disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Death Immediate Cause (Finel COPD Yeurs disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last Due to (or es a consequenca of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy parformed? 1□ Yes 21 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

The lew requires that the death certificate be executed pue Box 68760. been signed by the attending p should be detached for use as: P.0. this certificate has Division of Vital Attending Physician: director. funaral

Physician/Medical Examin Aq Completed Be Certification: To Hospital or Attend 24 hours after death Funeral Director: A death

Physician

/Medical

Examiner

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Funeral

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Funeral

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28a-f

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Hygiene. filed within

Pages 1 and 2 should be till ment of Health and Mental H lant; if them 27 is marked oth lury or other traumatic even

Department of Important; If any Injury or page.

Physician /Medical

Exa iner

72 hours after

21215-0020

Baltimore, Maryland

To the Hospital or Atta-within 24 hours after dea To the Funeral Director completely filled in by the 10

Registrar

Medical

1 Decritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

28b. Time of Injury

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be

M.D. 1201 Agora Drive Mohamad Alabrash

31. Date filed (Month, Day, Year) JAN 0 4 2001

27. Menner of Death

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registrer's Signeture

28a. Dete of Injury (Month, Day Year)

na Ko

28c. Injury et Work?

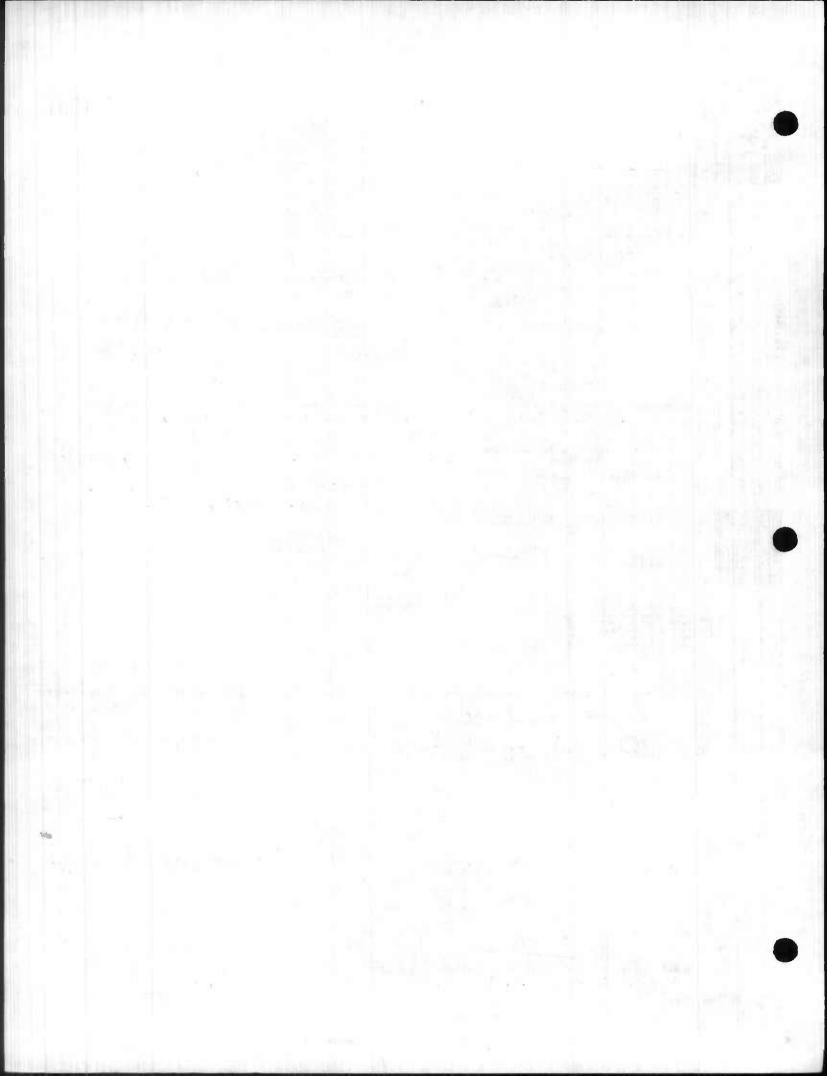
1 Yes 2 No

37612

Suite 2C Bel Air, MD

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)



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State of Maryland / Department of Health and Mental Hygiené

					- 1	Cer	tificate	of Death		Reg. No.	Ul	2327		
	Physician	-	ma (First, Middle,		-11-11				Month	- 10.10				
N	/Medical			Prinsk				4b. City, Town, or	De ce		000	17:12 bm		
	Examiner			SPITAL CE	11			RANDAL	INMOTS	DAI.	TIMORE			
Г	Funeral Director	5. Social Security	Number 6			last birthday) 7 Yrs.	If Under 1 Y Months D	raar If Undar 24 Hrs lays Hours Min	8. Data of B	irth (Pey, Year) 9, 1913	9. Birthple Countr	ROMANIA		
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	The start	10a. Stata	10b. County		10c. City, Town or Location						10	d. Insida City Limits		
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	or 28a-f a	10e. Streef and N	umber				10f. Zip Co			10g. Citizan of V		γ?		
			MT. WILS	ON LANE #	510			21208		U.S				
21215-0020	urs after death var, or theme 23 Examiner must by Furneral		11. Marital Status 1 Nevar Married 2 Married 3 Widowad 4 Divorced		lant Evar in U eas? ! (2) No as:		Vas Decedant Yas, specify □ Yas 2	t of Hispanic Origin? (Cuban, Maxican, Pual No <i>Specify:</i>	Specify Yas or N rto Rican, atc.)	lo- 14. Rac Blac Specify	What Country? S. A. Ice - Amarican Indian, ack, White, etc. WHITE Businass/Industry NHOME WHOME SIRKIN In, Stete, Zip Code) RE, MD 21212 - City or Town, Stata IMORE, MD & BROS., INC. /ILLE, MD 2120 Approximate			
20	right had hed	/0-	15. Decedenf's		Jucetion 16a. Dec			ecupation	orkina	16b. Kind of Busi		sinass/Industry		
2	led within 72 ho lygiene. He then "natural rt, the Medical. Completed	Elamentery/Se	(Specify only highest grade completed) ry/Secondary (0-12) Collega (1-4or 5											
Maryland 21	Cor the	12	12				WIFE			OWN HOME				
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Ma	d 2 and d 2 an		Name/Ralationshi		SON		_							
6	Hoat Sher	20a Mathod of Disposition 20b, Place of Disposition (Name of Data 20c, Location - City or Town, Stata												
altimore	Pages nent of ant: If it ary or o	1XXBurial		Ramoval from Si	tata	cemetery, crem	netory or othe	r piece)	1/3/01	BALTI	MORE,	MD		
Balt	Departi Departi Importa any inji	21. Signatura	grana Service (grisee		22	. Na <i>m</i> e end A	ddrass of Facility	SOL L N ROAD	EVINSON - PIKESV	& BROS	S., INC. MD 21208		
		23a. Part 1. Enter shock for he	the disaasa, or control failura. List or	omplications that celly one cause on as	used tha daal ch lina.			f dying, such as cardie				Approximate Intarval Batween		
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п	Examiner	disaasa or condit resulting in death	ion	a. My	caro	cal	Lutare	ction			1 (Ldays		
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0	ned be dete									Yes 2 10 No	3	ably 4 Dilkilow		
Records,	The law requires that the death cerpate has been signed by the attending page 2 should be detached for use Completed by Physician/N.									as an autopsy formed?	ava	ra autopsy findings liable prior to aplation of ceuse aath?		
Re	The law ate has page 2								10	Yes 20 No		Yas 20 No		
Vital		25. Wes case raf	erred to medical		-			26. Place of De	eath (Check only					
1	nysician nis certifi il director	axaminar? 1 ☐ Yes 2	No	Hospital: 12 In	patient 2	ER/Outpatien	t 3□ DOA	Other:		sidance 6 □Oth	nar (Specify)		
on of	Phasial I	27. Manner of De 1 Natural 2 Accident	eth 5 Panding invastiga	28e. Deta of (Month	Injury , Dey Year)	28b. Time of Injury	28c.	Injury at Work?	28d. Describe	e how injury occur	rred			
ivision	r Attending tar death. rector: Atta by the fune tificatior	3 Suicida 4 Homicide	6 ☐ Could no	be 28a. Place o	of Injury - At h	ome, farm, sfri	eet, factory, or		28f. Location City or T	(Street end Numi own, Stete)	ber or Rurel	Route Number,		

Medical Certifi Rathschild 31. Dete filed (Month, Day, Year) State Registrar

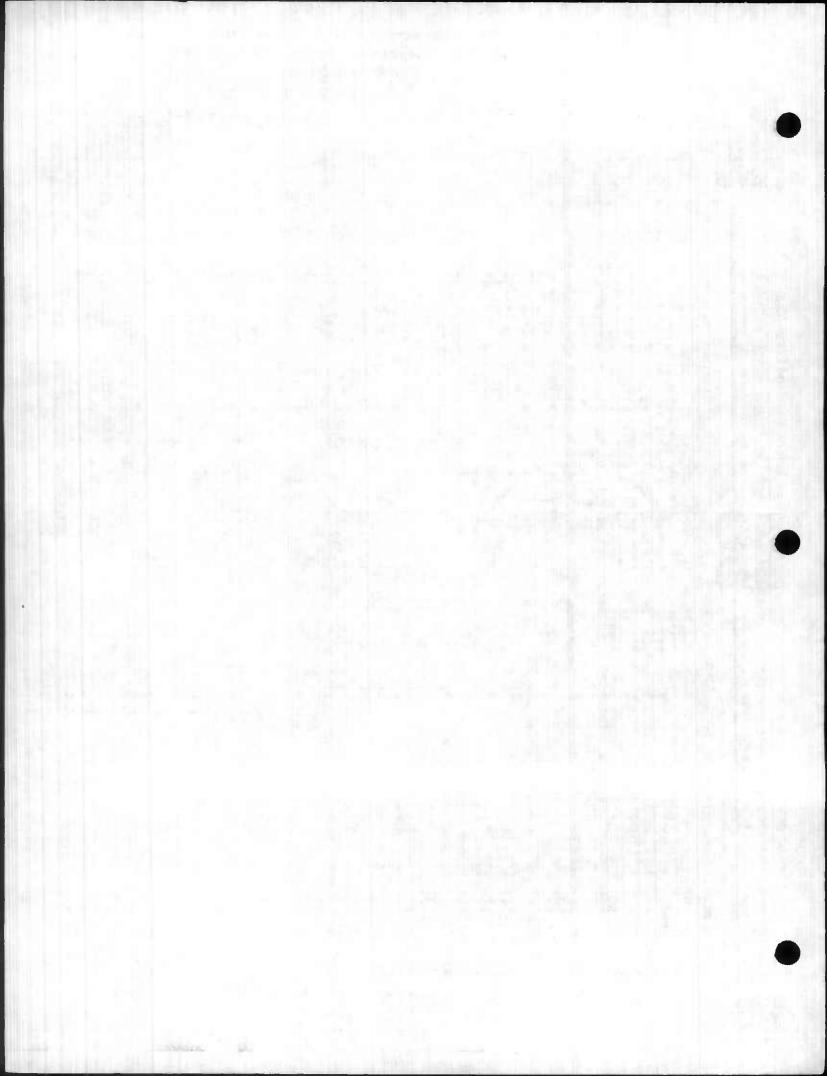
29a. Cartifiar

1 Certifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and dua to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29c. Licensa number

MD 30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print)

Rd Pikesville, mo 4000 32. Registral's Signatura



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Dep	partment of Health	and Mental Hygiene
Otato of Maryland / Dop	ditilionic of Floatti	and montain gione
C	rtificate of Dogt	h

	Decedent's Name (First, Middle, Las	f)	Cei	tificate o	f Death	Re-	g. No.	3. Time of Death			
Physician /Medical		George R. Palmer						2000 5:40			
Examiner Funeral Director	4a Facility Name (If not institution, give ORTH AR 5. Social Security Number 218 26 8224	UNDEL +	OSP	If Under 1 Yes	Glen Par If Under 24 Hrs			9. Birthplace (State or Forei Country) Michigan			
	Usual Residence of Decedent	10- 0	y, Town or Lo			Depos 17	1321				
or 28s-f show be notified at Director	Maryland Anne Art		10d. Inside City Lim 1 ☐ Yes 230								
Dir	10e. Street and Number 7817 Waterview D	rive		10f. Zip Code	226	10	10g. Citizen of What Country?				
al, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: W • W •	1	Was Decedent of	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race	- American Indien, White, etc. White			
"natur edicel	15. Decedent's Ed (Specify only highest gred	ucetion de com <i>pleted)</i>	16e. Deced	lent's Usual Occ kind of work dor OO NOT use ret	e during most of wo	orking 1	6b. Kind of Bus	Kind of Business/Industry Railroad			
r than tre M	Elementery/Secondary (0-12) 12th	Cotlege (1-4or 5+)	Car	Inspec	tor		Railr				
ever Be	17. Fether's Neme (First, Middle, Last)	ay G. Palmer				ame (First, Middle, Maiden Surneme) Floy D. Swarthout					
and e m	19a. Informent's Name/Relationship (7						er, City or Town, Stete, Zip Code)				
item 27 other tr	Margaret Palmer	/ Wife			.ew Drive			ch, MD. 21226			
y or o	20e. Method of Disposition 1										
Departmen important: any injury pnce.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225										
ysician Medical kaminer Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Py E Due to (o	or es a consec Programa a consecuencia de la consec	D Truence of):	VID Emp			Onset and Death			
physicia as the bur edical	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c d	r as a conseq	3 E 7	35 0	TUL	ITU	•			
atached for use a Physician/M	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause	given in Part I.	23b. Dld tot	pacco uae cont	ribute to the cause of de			
				1 □ Ye	s 2 No 3 Probably 450Unkr						
2 should						24a. Was an		24b. Were autopsy findin evailable prior to completion of ceuse of death?			
paga Com						1□ Ye	s 2100	1 ☐ Yes 2 No			
ertific Be	25. Was cese referred to medical examiner?	Hospitel:			Other:	eth (Check only one					
5 5	27. Menner of Death Nature 5 Pending Pending investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Ir	ijury at Vork? ☐ Yes 2☐ No	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
is after death. I Director: After t led in by the funeral Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office	00	28f. Location (Str City or Town	eet end Numbe , Stete)	r or Rurel Route Number,			
n 24 hou he Funer pletely fill edical	(Check only 2 Medicat Exam	retcian: To the best of my kno Iner: On the basis of examina end menner stated.	wledge, deeth tion and/or in	vestigation, in m	y opinion, death occ	urred et the time, da	ite and place, ar	nd due to the cause(s)			
E = E	29b. Signeture end title of certifier	11011		29c. Lice	nse number	29	d. Date signed	(Month, Day, Year)			

State Registrar 31. Date filed (Month, Dey, Year) JAN 0 4 2001

MORTH

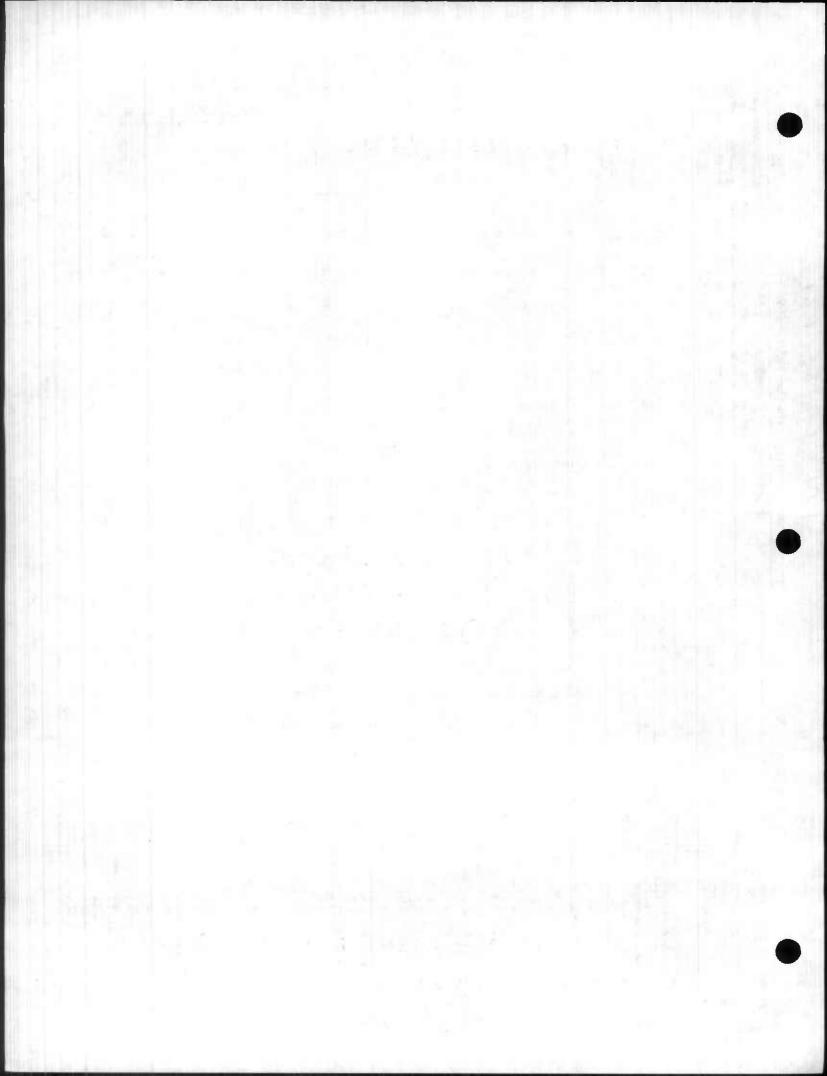
Of person who completed ceuse of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE, GLEN BURNERS

Pey, Year) 32. Registrar's Signature, MD 2 1061 32. Registrar's Signature

DHMH 16 Rev 6/95

PALMER, GEORGE

ORIGINAL



Physician /Medical Examiner **Funeral**

Director

Peges 1 and 2 should be filled within 72 hours after deeth with the Mt nert of Health and Mental Hyglena.
Int: If Item 27 Is marked other than "natural", or Itema 23a or 28a-1 into or other traumatic avant, it was added to the traumatic avant.

PARKS NOBIE

Directo 7355 Furnace Branch Road 21060 Funeral 12. Was Decedent Ever In U,S. Armed Forces?
1 ☐ Yas 2 ☒ No
If Yes, Give
Year or Dates: 11. Marital Status 1 Nevar Married 2 Married 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) College (1-4or 5+) Cashier 17. Fathar's Nama (First, Middla, Last) Be Franklin Phillips Caroline 19a. Informant's Name/Relationship (Type, Print) Daniel Lynn Parks/ Husband Baltimore, 20b. Place of Disposition (Name of cematary, cramatory or other place) 20e. Method of Disposition permit. Peges
Department of
Important: If its
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funeral Service Licensee Ward 51 aura (5 **Physician** /Medical Immediate Cause (Final disease or condition resulting in daath) MYOCARDIAL Examiner Physician/Medical Examiner attending physician and for use as the bunal-transit certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last ERTENSION Box 68760. Due to (or as a consequence of) P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by habetes Mellitus Division of Vital Records, by been si Completed page 2 s has DEIZURE DISORDER certificate Physician: 25. Was case referred to medical examiner? director Be Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No P After this 28a. Data of Injury (Month, Day Year) 27. Manner of Death Injury at Work? Certification: or Attanding 5 Pending invastigation 1 Naturel 1 Yes 2 No death. 2 Accident Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29c. License number 29b. Signatura and title of certifier 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) vin 6600 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra repenta **DHMH 16 Rev 6/95**

3. Time of Death

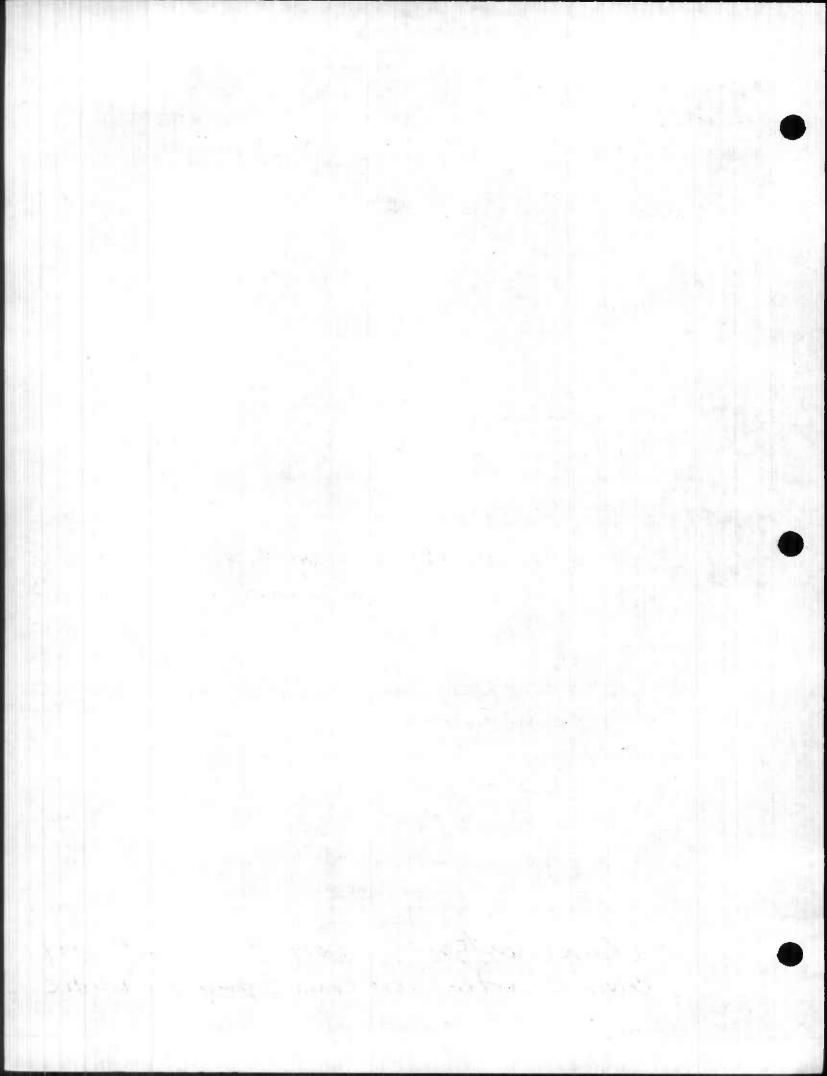
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Nobie Parks 3.11Pm 2000 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death # Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 26, 1947 ARUNDEL DSPITA COUNTY NORTH Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 M 2 X F 53 214-54-8138 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Count 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Specify: Black 16b. Kind of Business/Industry Pharmacv 18. Mother's Name (First, Middle, Maiden Surname) Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7355 Furnace Branch Road Glen Burnie, MD 21060 20c. Location - City or Town, State Chesapeake Crematory, Incl/3/01 Beltsville, MD 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate intarval Batween Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? 1 Yas 20 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

29d. Data signad (Month, Day, Year)

Highway Glen Burnie

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month Dey **Physician** 0000 0440 Dec 10 30 a /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Monggomer GKm 11235 Teamer 4 If Under 1 Year | If Under 24 Hrs/ 5. Social Security Number 9. Birthplece (State or Foreign & SAV 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min. UNK. 1□ M 20 F 408-20-2654 79 Yrs. Jan 16, 1921 Director Usuel Residence of Decadent with the Maryland 10d. Inside City Limits 10e State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryfan Depentment of Health end Mental Hygiane. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or onfer treatmetic event, if a Marcal Examine matter any Injury or other treatmetic event, if a Marcal Examine matter is not lifted. IN Richmond XYes 2 No Wayne Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 516 S.W. 15th Street 47374 TISA Funeral 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Stetus Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3€ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use ratired) Elementery/Secondery (0-12) Cotlege (1-4or 5+) Secretary 12 Insurance Company 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) 8 John M. Siler Margaret Ella Wells 10 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Kenneth A. Raqlin / 2203 Honeystone Way, Brookeville, MD 20833 Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Farlham Cemetery January 3, 2001 Richmond, 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensea Victor P. Doada, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner certificate be executed and -trens Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): ettending physician a for use es the burial-Box 68760 Physician/Medical Due to (or es e consequence of): 98 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. eu 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 Unknown signed by thet Records, þ The law requires 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy performed? Completed peen s completion of cause of deeth? hes 2 No 1 ☐ Yes 2 ☐ No certificete Division of Vital Physician: director. 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 this After this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: or Attending 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 24 hours efter deeth. Investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homleide Hospital 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) within 2 To the ag. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

um pma

mo DME

32. Registrer's Signature

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

BRECHER

30

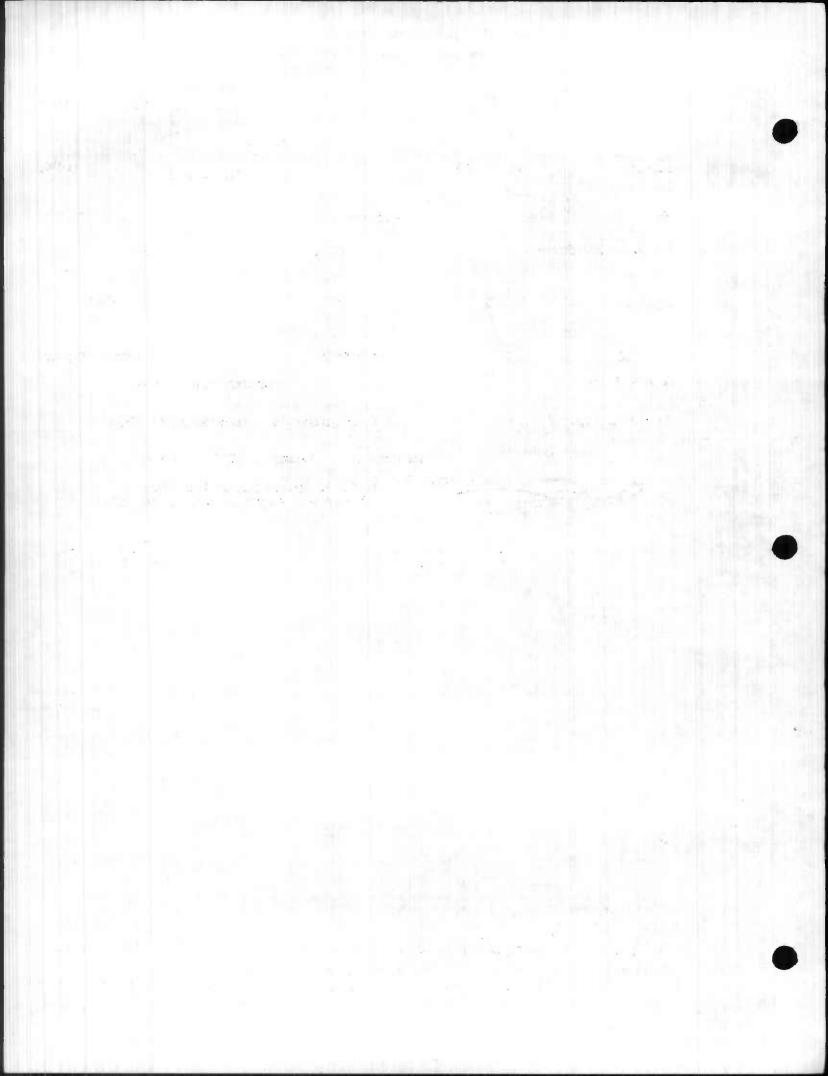
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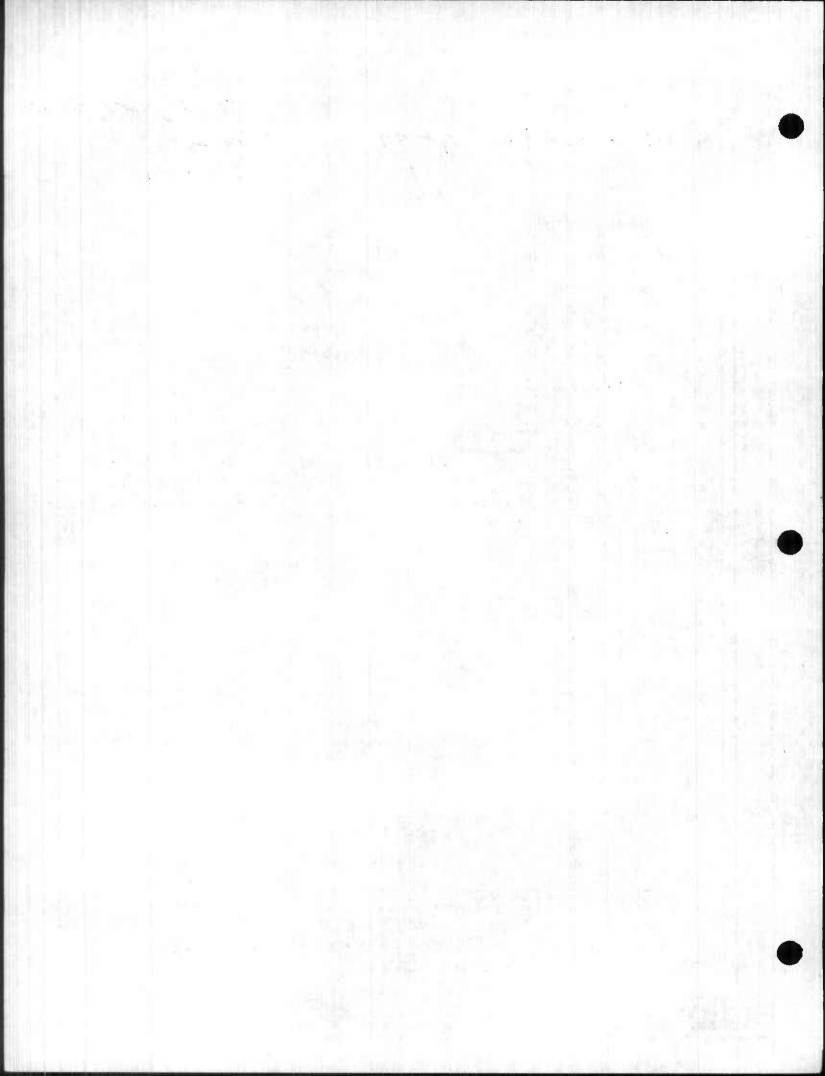
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth Veer **Physician** Summenile 2000 De /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9. Birthpleca (Stete or Foreign 8. Date of Birth Month, Day, If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In rs. last birthday) Funeral Deys 100M 20 F 7 gyrs. Months Hours 219-01-8589 Usuel Residence of Decedent Director with the Maryland 10d. Inside Pity Limits 10a State 10h County 10c. City. Town or Location 1 Yes 2 No Baltimor Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with I Department of Heelih end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 2 yi highry or other traumatic event, the Med on Examine must be in once. USA 70 by Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cubar, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Bleck, White, etc. 1 Never Merried 2 Merried Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (9-12) College (1-4or 5+) (516.d 18. Mother's Nema (First, Middle, Maiden Sumeme) 17. Fether's Nema (First, Middle, Last) Summerville 25 19b. Mailing Address (Street, end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Raletionship (Type, Pnint) Mento Baltimore 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecilit wera 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician end for use as the burial-transit The lew requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieled events resulting in death) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Was an autopsy performed? After this certificate has a funerel director, page 2 a 2/1 No 1 Yes Hospital or Attending Physician: 25. Wes cese referred to medical examiner? Be 28. Pleca of Death (Check only one) 1□ Yes 2☑ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Neturel 5 Pending invastigation in 24 hours and the Funeral Director: Aft trials filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 28i. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) end menner steted. edicai 29e. Certifier (Check only one) To the P 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifie 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) kre Ave WasT 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

ORIGINAL

oaks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** SCHMIDT DECEMBER 24, 2000 JOHN /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALT (MORE C(T)

ar If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
OCT. 2, 1937 GOOD SAMARITAN HOSPITAL If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Davs 10XM 20 F 213-36-5357 63 Director MD. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City. Town or Location 10b County "naturel", or items 23s or 28s-f show 1 Yes 2 No BALTIMORE CITY MD. N/A Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3904 HUDSON STREET 21224 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3√Widowed 4 □ Divorced r than "natur Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Hygiena. MILL WRIGHT WESTERN ELECTRIC 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If item 27 is marked of MATTHEW CHRISTIAN SCHMIDT FLORENCE HERBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4607 WOODLEA AVE., BALTIMORE, MD. 21206 DANA SCHMIDT/DAUGHTER item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 0 12/28/00 BALTIMORE, MD. OAK LAWN CEMETERY 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD. 21224 Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final . HEUTE MYOCARDIAL INFARCTION disease or condition resulting in death) Examiner Examiner tha death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician e s the buriel-t Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) use 23b. Did tobacco use contribute to the cause of deeth? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the a 1 Yes 2 No 3 Probably 4 Unknown REMAL DISEASE Completed by agua I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy BRTGRY is cartificate has I 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funeral 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident ofter death Director: A 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours eff Funeral Di letely filled in 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie P12561 DECEMBER 24, 2000 vetor 30. Name end againess of person who completed cause of death (Item 23e) (Type, Print)

5601 LOCH RAVEN BLUD,

32. Registrar's Signature

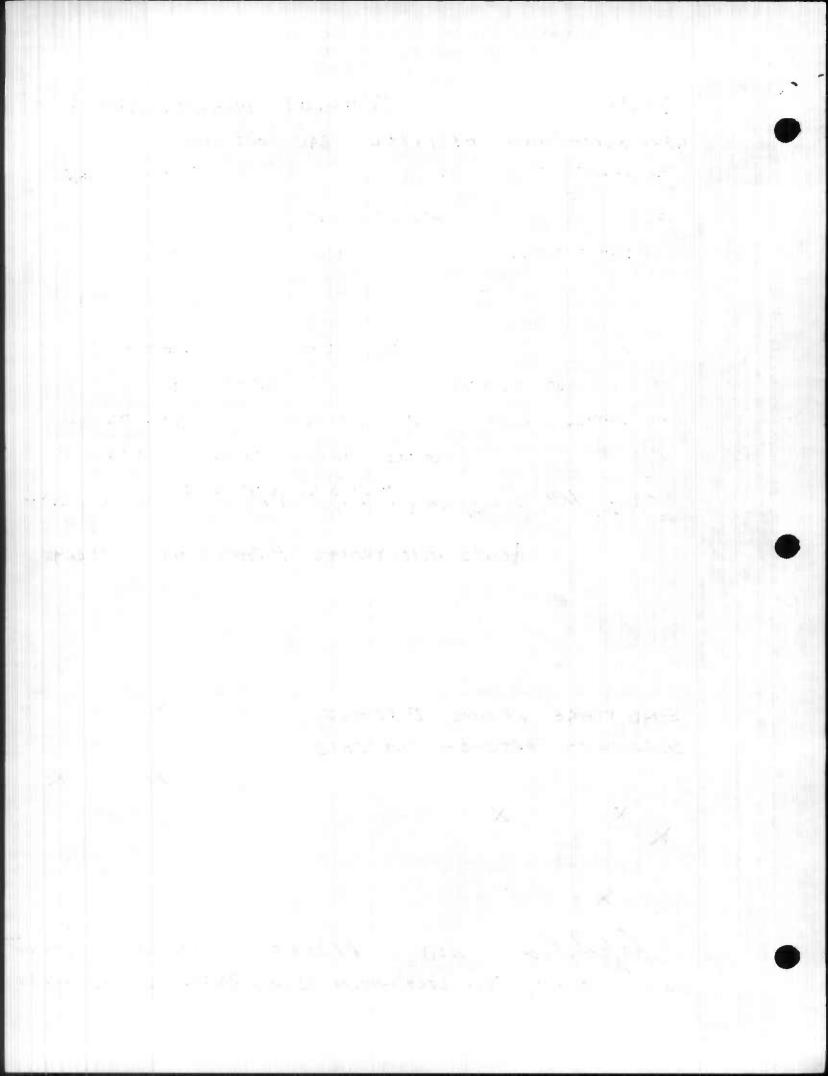
BALTIMORE MD 21239

Registrar

20000

RAPHAEZ DOS 31. Date filed (Month, Day, Year)

JAN 0 4 2001



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Year Month 12:50 PM Shriver December illian 31 2000 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Maryland If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplaca (Steta or Foreign Country) Months Days Hours 1□ M 2□ F 214-24-9803 71 Dec. 2, 1929 Maryland Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2519 McComas Avenue 21222 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 25 No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, atc. 1 □ Nevar Married 2 □ Married 1 ☐ Yes 21 No Specify: 3₺ Widowed 4 Divorced White 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry Etementery/Secondery (0-12) 8 Years Cotlege (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Bigler Bowers Helen Haglin 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Retationship (Type, Print) Edith Shriver (Daughter) 8249 Longpoint Road Dundalk, Maryland 20b. Placa of Disposition (Name of cematery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Garrison Forest V.A.Cem. 1/4/2001 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximata tnterval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) 12 days Cerebral Vascular Accident Due to (or as a consequenca of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated evants resulting in death) Last Due to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part If. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part f. 1 Yee 2 No 3 Probably 4 Unknown End Stage Renal Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ★ Inpatient 2 ER/Outpatient 3 DOA

the attending physician and thed for use as the burial-transit the death certificate be executed been signed by the should be detached The law requires that Olvision of Vital Records, After this certificate hes funeral director, Attanding ours after deab

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or hems 23s or 28s-f show the Medical Examiner must be notified at

72 hours after

filled within

should be Mental marked

Baltimore,

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permit. Pages 1 and 2 at Department of Health an Important: If Item 27 is 1 any injury or other traus

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Physician/Medical Examiner by Completed Be Certification: To 4 Thomicide

25. Was case referred to medicat 1 Yes 2 No 27. Manner of Death 1 Naturat 2 Accident 3 ☐ Suicide

5 Pending investigation

6 Could not be determined

28b. Time of Injury

28c. tnjury at Work? 1 Yes 2 No 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

Baltimore, Maryland 21201

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the causa(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and titte of certifier an

29c. License number P14666

29d. Date signed (Month, Dey, Year) December 31, 2000

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

22 South Green Street PAUL SACK - University of Maryland

31. Date filed (Month, Dey, Year) 32. Registrar's Signatura

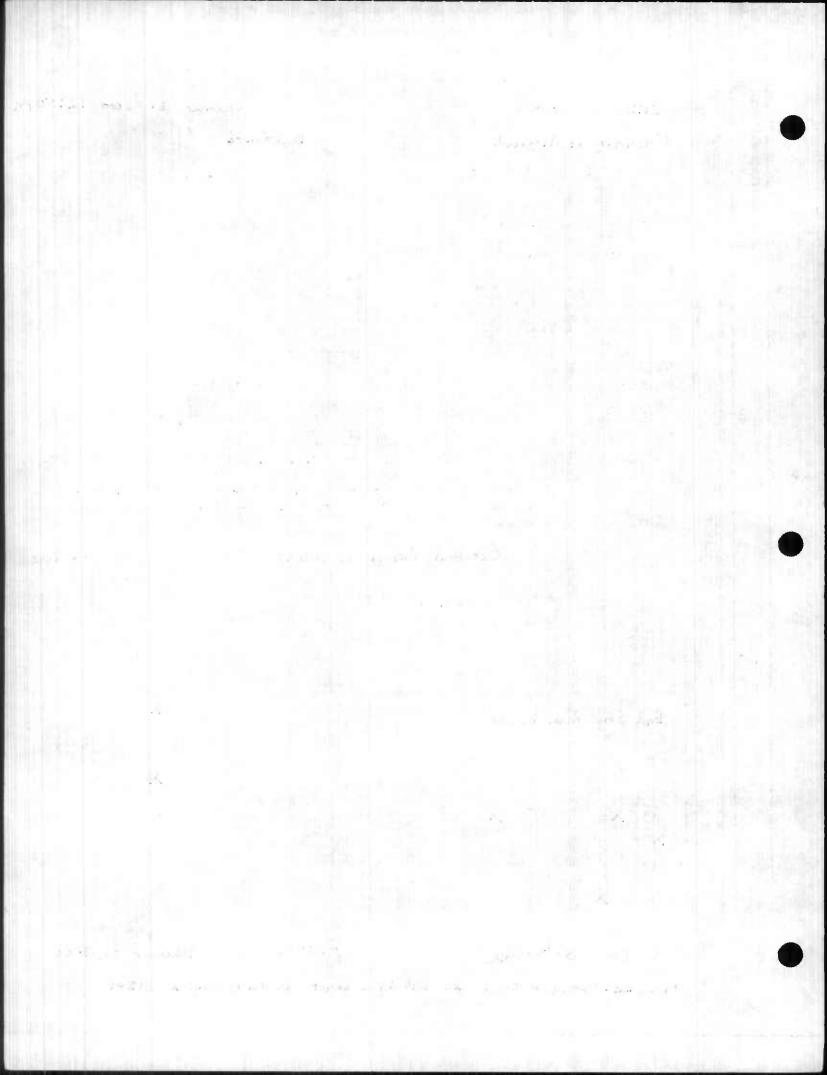
Registrar JAN U 4 2001

29e. Certifier

edicai

oorka

To the Hospital o within 24 hours af To the Funeral Di completely filled in

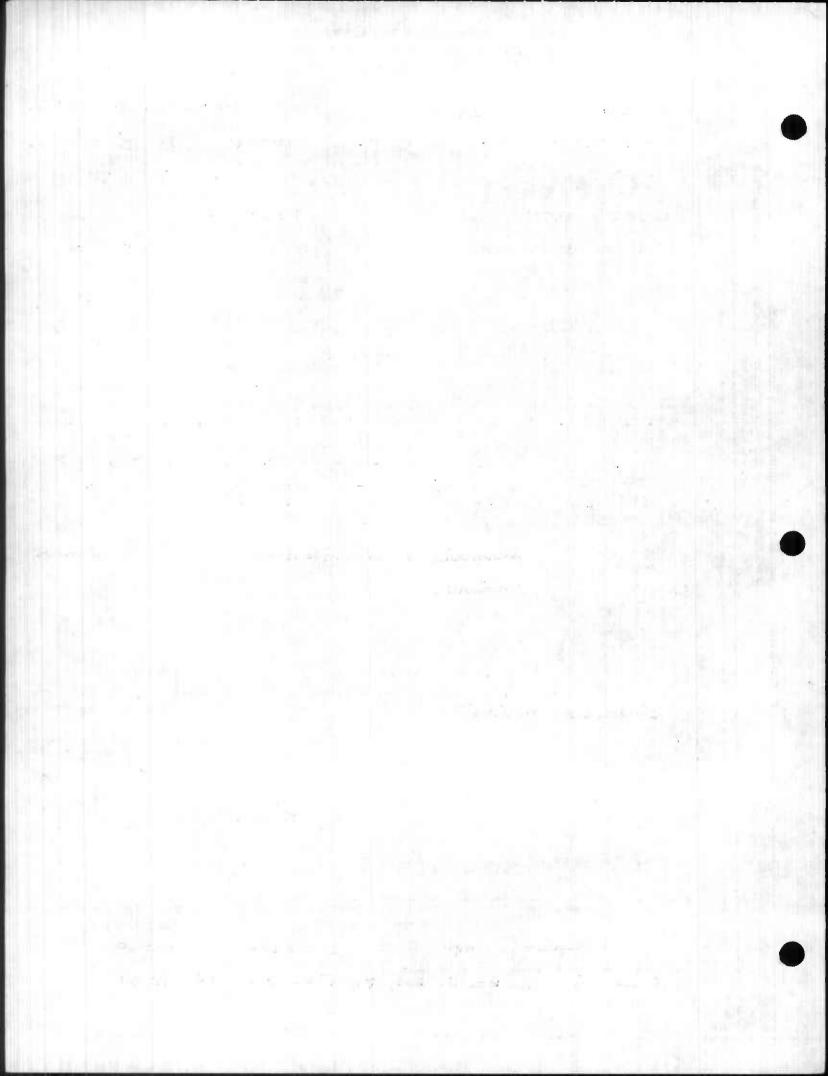


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State of Maryland / Department of Health and Mental Hygiene 0 42334

					Cei	tificat	e of	Death		Re	g. No.	77 6	.009	
Dhusisis	_	1. Decedent's Nama (First, Middle, Lest) Herminia Elizabeth Schmidt 4a Facility Nama (If not institution, give street and number)						77 SO 1 Y		2. Data of Death Month Day Yes			3. Time of Death	
Physicia /Medic Examin	al							4b. City, Town,	Dec	embe	2 30,	2000	1:15 AM	
Examin	21	Genesis Heritage	Meridian	Eldero	are (Ctr.		Dunda						
Funeral Director		5. Social Security Number 6. S		e (In yrs. las		If Under Months			Ain. (Mon		Year) ,1918		placa (State or Foreign ntry) ryland	
ehow of at	10a. State 10b. County 10c. City, Town or Location											0d. Inside City Limits NOXYes 2 □ No		
s or 28a-	5												,	
5-UUSO 72 hours effect death with the Maryland natural, or theme 23s or 28s-f show	by Fur	11. Marital Status 1 Nevar Married 2 Married 3 XWidowed 4 Divorced	Armad Forces?						? (Specify Yas uerto Rican, et	Blac	14. Race - Amarican Indian, Black, White, etc. Specify: White			
- c -	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 10 Years	College (1-4or 5+) (Give kind of work life, DO NOT use				ork done ise retire	during most of	working		16b. Kind of Bi			
be filed with tal Hygiena.		17. Father's Nama (First, Middla, Last)							Name (First, A					
id be sental ked o	To Be	Herman Ramsel Mary Elizabeth Eir										nhau	S	
Mar 12 sho h and 7 le m treum		19a. tnformant's Name/Relationship (t and Number o	r Rural Routa	Number,	City or Town,	State, Zip		
or Heal	1	20a. Method of Disposition 1 ⊠ Bunal 2 □ Cremation 3 □	Removal from State	20b. Ptac cem	e of Dispo	sition (Na matory or o	me of other ple	ace)	Date	4	20c. Location -	City or To		
Baltime permit. Pag Department Important: If eny Injury o		4 Donation 15 Other (Specify) Sacred Ht. of Jesus Cem. 1/2/2001 Dundalk, Mar 21. Signature of Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.												
Physician /Medical		7922 Wise Ave. Dundalk, Maryland 21222 23a. Part. Enter the disease or conglications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation or heart follows in the cause on each line. Immediate Cause (Final												
Examiner		Immediate Cause (Final disease or condition resulting in death) Generalized Debilitetion Due to (or as a consequence of):												
	Je.		Dame		s a consec	querica or,	•							
g physician and es the burial-transit	Examiner	Sequentially list conditions, if any, leeding to immadiate cause. Enter Undertying Cause (Disease or injury that initiated avents Due to (or as a consequence of):									1			
X 68 760, sertificate be ex ding physician se es the burial	8	Cause (Disease or injury that initiated avents resulting in death) Last	Due to (or as a consequence of):											
D. BOX (clan									23b. Did tobacco use contribute to the cause of death?				
T the dot	Phys	Diabelas	ontributing to death to	to death but not resulting in the underlying cause given in Part t.									bably 4 Unknown	
OT VITAL RECOTOS, P.O. BOX Physicien: The law requires that the death cer this certificate has been signed by the attendin rel director, page 2 should be deteched for use	Completed by								248	24a. Was an autopsy performed?		a\ cc	fere autopsy findings vailable prior to completion of cause death?	
ysicien: The law sectificate has director, page 2.	Com				113					1□ Ye	s 200	1	□Yes 2000	
oentificate	Be	25. Was case referred to medical examiner?	Hospital:					thor:	Death (Check		-			
Physicien: this certifical director,	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 L Inpati	-	NOutpatier		OA	4 Mursi	Nursing Home 5 Residence 6 Other (Specify)					
	Certification:	1 🖾 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year) Injury Work? M 1 Yes 2 No							28d. Describe how injury occurred				
DIVISION Hospital or Attending 24 hours ettar death. Funeral Director: After stely filled in by the fune														
Hose 24 ho Fune Ptely fi	edical		ysician: To the best niner: On the basis of and mannar si	f examinetion										
within 2 To the		29b. Signatura and titte of certifier				29	c. Licer	nse number		2	9d. Date signe	ed (Month,	Day, Year)	
F3F8		> S. Pagu		wb	Bi.		۵	537	20		12/31	(00)		
7		30. Nama and address of person who completed cause of death (Hem 23a) (Type, Print) S. Faguras, 2112 Belair Rd, #1, Fallston, mD 2104									+			
Stat Registra		31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur	a /	9	100	rks						

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Deeth Day Month Year **Physician** Frances SCebor December 28 6:15 82 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, giva street end number) 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) Johns Hopkins Bayview Medical Cen 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Baltimore Center Birthplaca (Stata or Foreign Country) **Funeral** Months 1□M 219 F 218-48-4937 52 Maryland Director June 27, 1948 Usual Rasidence of Decedant 10d. insida City Limits 10a. Stata 10b. County 10c. City, Town or Location Hydene. other than "naturel", or itema 23s or 28s-f ehovent, the Medical Examiner must be notified at XXYas 2 No N/A Baltimore City Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21224 United States 6923 Gough Street Funeral death 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ₹₹\$No If Yas, Giva Yaer or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - Amarican Indian Black, Whita, atc. 1 ☐ Nevar Married 2 ☒ Married Baltimore, Maryland 21215-0036 1 Yas 2 XNo Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade complated) (Giva kind of work dona during most of working lifa. DO NOT usa retired) permit. Peges 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "n any Injury or other traumatic event, the Med Botce. Elamentary/Secondary (0-12) College (1-4or 5+) Years Medical Billing Medical/Hospital 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nema (First, Middle, Last) Be Josephine Mioduszewski Frank Szczybor 19a. Informant's Name/Ratationship (Type, Print) (Husband) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mr. George R. Harrison 6923 Gough Street Baltimore, Maryland 21224 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovel from Stata Hillton Service Corp. 1/3/2001 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Furnity Service Lo Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part. Enter the disease, or complications that caused the distribution and an enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Sep Sis 7days Examiner Dua to (or es a consequança of) Examiner attending physicien end for use as the burial-transit certificete be executed Sequentielly list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in death) Last Due to (or es e consequança of). Box 68760. Physician/Medical Due to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown renal Division of Vital Records, by 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performed? Completed Necrosis 1 Yas 2 No 1 ☐ Yas 2 No 9 25. Was casa ratarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 Suppatient 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) To 1 Yas ZENo 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28d. Dascribe how injury occurred 28c. Injury at Work? Hospital or Attending Prince Functs of End of Prince Function: After the following filled in by the functions Certification: 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 ☐ Homicida To the Hospital of within 24 hours of To the Funeral C completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edicai 29a. Certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) 29b. Signatura and titla of certifier MENTARI es 000 MD 30. Nama and addrass of person who complated causa of death (Item 23e) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

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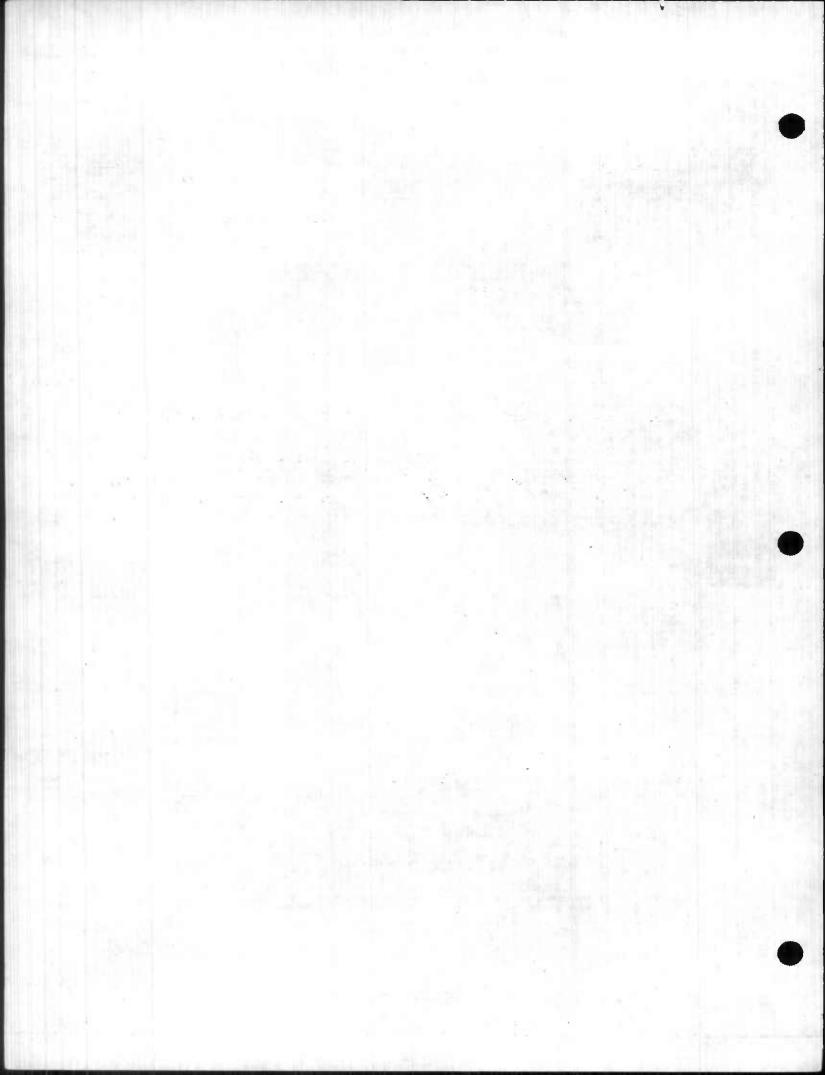
Evelyn Mentar
31. Dete filed (Month, Day, Year)

MD

32. Registrer's Signature

ORIGINAL

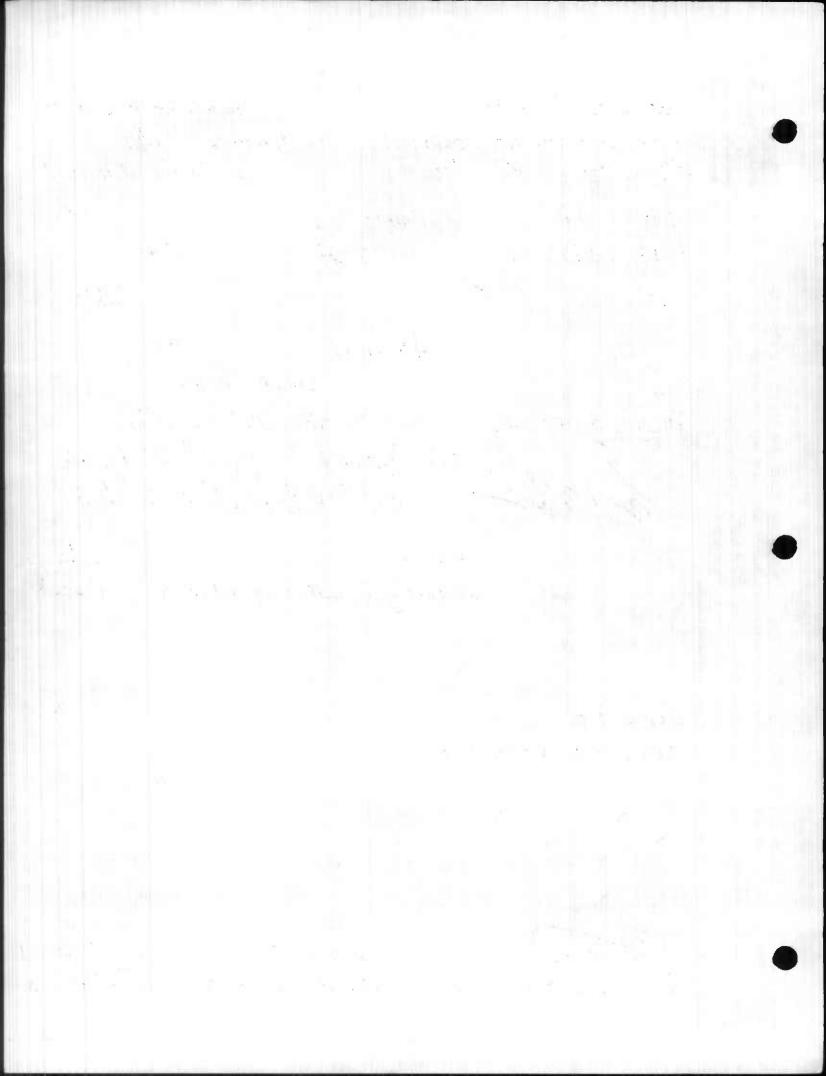
4940 Eastern Ave Baltimore MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Smith Ressie December 27 2000 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Baltimore
If Under 24 Hrs. 8. Detection Hospita
7. Age (In prog last birthday) Samaritan last birthday) 9. Birthplece (Stete or Foreign **Funeral** 10 M 20 F Months Days -22-586 Hours Director 10c. City, Town or Location 10a State 10d. inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Baltimore 1 les 2 No Director 10g. Citizen of Whet Country? 10f, Zip Code 2/2/4 Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

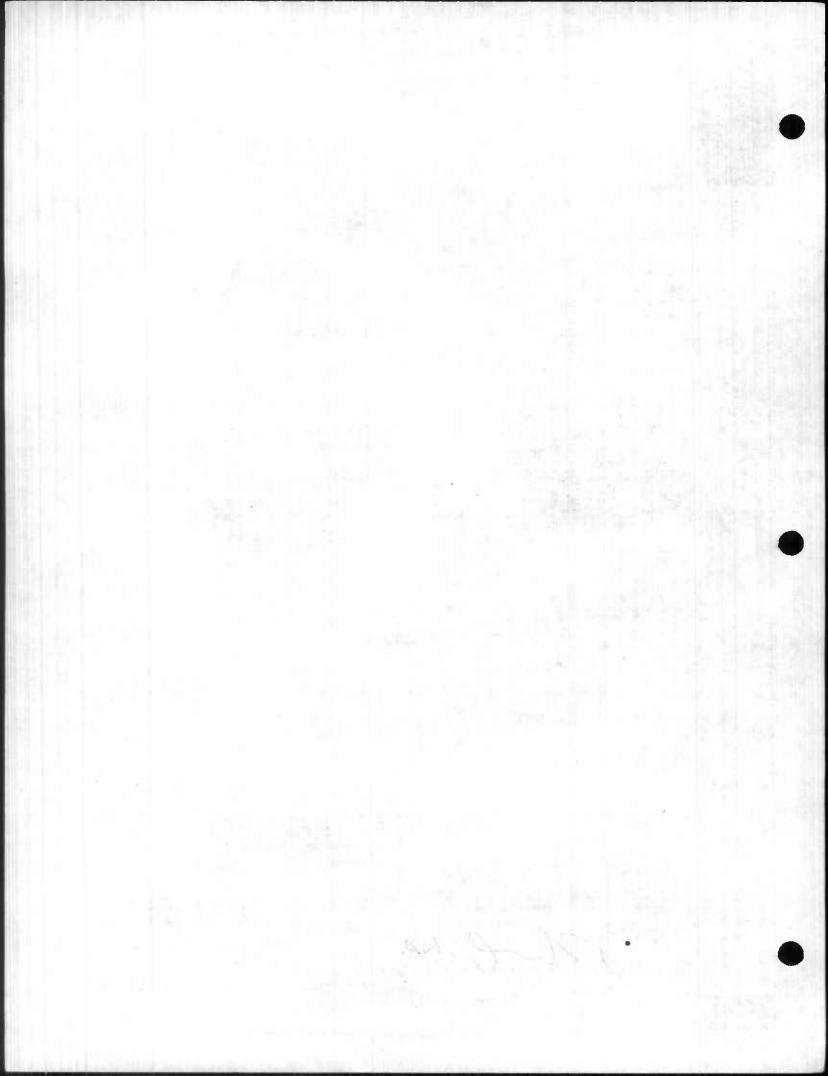
1 Yes 2 No If Yes, Give Year or Dates: 14. Raca - American Indian, 11. Mantei Stetus Bleck, White, etc. 1 Neyer Married 2 Married 1 Yes 20 No Specify: Baltimore, Maryland 21215-0020 by 3 Widowed 4 □ Divorced Hygiene. other than "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
| | life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: if Item 27 is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) ousewife 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) unk. 19a, Informant's Name/Relationship (Type, 20a. Method of Disp 1 Burial 2 DK 6 Other (Specify) e, or complications that caused the death. Do n List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760 physician Physician/Medical the Due to (or as a consequence of) ed by the detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown dementia Completed by 24b. Were eutopsy findings evellable prior to 24a. Was an autopsy performed? seizure disorder completion of cause of deeth? this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Naturel after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, end due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Yeer) 29c. License number 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) aber 5601 mo 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature State JAN Registrar **DHMH 16 Rev 6/95**



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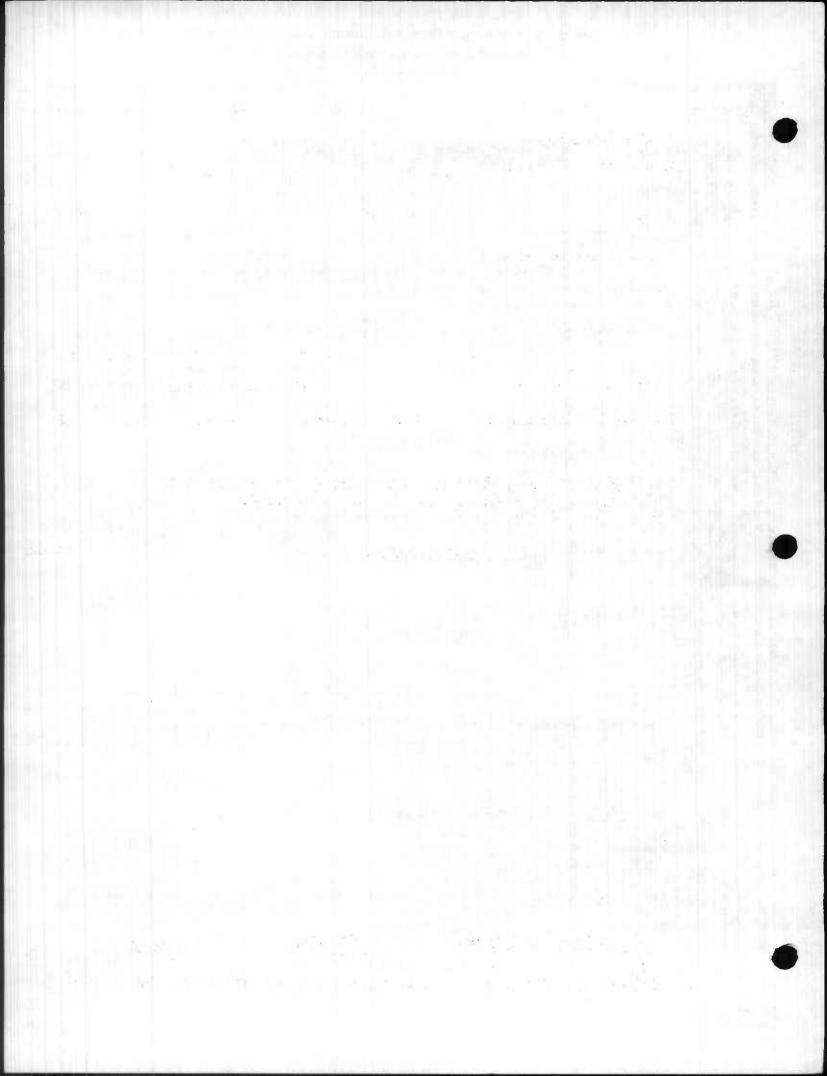
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 2 3

					Cer	tificate	of E	eath			Reg. No.	, 4	2339			
DI	hysician	Decedent's Name (First, Middle, Last)								2. Date of De	Day	Year	3. Time of Death			
	/Medical	HELEN LYDIA SCH								Decemb	er 25, 2	2000	11:15 AM			
E	xaminer		a Facility Name (If not Institution, giva street and number) 3725 Ellerslie Avenue							City, Town, or Location of Death Baltimore 4c. County of Death						
	neral ector		Sax 7. A 1 □ M 2 ☑ F	7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. Months Days Hours Min.						8. Date of Bird (Month, Da May 29	8. Date of Birth (Month, Day, Year) May 29, 1920 9. Birthplace (State or Fore Country) Virginia					
ryland	anow Filat	Usual Residence of Decedent 10a. Stata 10b. County		10c. City, T	own or Loc							1	0d. Insida City Limits			
M Ma	rector	MD			ватт	imore							tX Yas 2 No			
€ 5	r items 23a or 28a-fs other mast be notelled Funeral Director	10e. Street and Number 3725 Ellerslie		10f. Zip Code 21218						10g. Citizen of What Country? 8 USA						
after a	by	11. Marital Status 1 🖾 Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 K	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates;			13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R					k, Whita,	Americen Indian, Whita, atc. White			
5-0 72 ho	rt, the Medical Ex-	15. Decedent's E (Specify only highest gr		ucation 16a. I			Occupa done di	tion uning most	of worki	ing	16b. Kind of B	usiness/în	dustry			
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should be filed within and Mental Hygiena.	S S	17. Father's Nama (First, Middla, Lasi	+5		teacher 18. Mother's N			's Nema	ema (First, Middle, Maiden Sumame			religion »				
ld be ental	To Be	William H. Sch	•							paulding						
laryla 2 should and Mer	T T	19a. Informant's Name/Relationship			19b. Malling	g Address (S	Street a			ural Route Number, City or Town, State, Zip Code)						
t and 2 Haalth a	or tra	Elizabeth Loveloc	k/sister		15895	Maub	ert	Ave	SanI	Leandro	, CA 9	5478				
20 20 20	important; it tem 27 is merked other truin any Injury or other traumatic event, the Monce. To Be Comp	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Onation 5 Other (Special Control Con		cem	e of Dispos etery, crem	sition (Name latory or oth	of er place)		Date	20c. Location	City or To	own, State			
Baltimo	any Inju	21. Signature of Europea Service Licenses Roundle S. Wade, Director State Anatomy Board 655 W. Baltimore, MD 21201										more	Street			
Physi /Med Exam	dical	25a. Pet 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e.							rrest,	1	Approximate Interval Between Onset and Death					
	e	Due to (or as a consequence of):														
: 68760, rifficete be executed	g physician and es the buriel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evenls resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):														
Box	for use								b. Did tobacco use contribute to the cause of death?							
O. the day	detached detached	Part II. Other significant conditions	Part II. Other eignificant condifions contributing to death but not resulting in the underly								1 Yes 2 XNo 3 Probably 4 Unknow					
Cords	should be										an autopsy ormed?	ev	ere autopsy findings allable prior to impletion of cause death?			
	2 0	Market Carrier								10	vas skun		Yes 2□ No			
	o Co	25. Wes casa refarred to medical						26. Piace	of Death	(Check only		1	3 163 2 2 160			
	To B	examiner?	Hospital:	tient 2 ER	VOutpatient	3□ DOA	Othe			./	dence 6 □Ott	er (Speci	(y)			
Vision of Attending Physic deeth.	= 10	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	M 280	i. Injury Work 1 □ Y	at ? ′es 2□N	28d. Describe how Injury occurred									
Division of or Attending a star deeth.	Certification:	3 Suicide 6 Could not to determined	e, farm, stre	n, street, factory, office 28f. Location City or 1					n (Street and Number or Rural Route Number, Town, State)							
Division To the Hospital or Attending I within 24 hours after deeth.	plataly fille	29a. Certifier Certifying Pt (Check only one) 2 Medical Exa	nysician: To the bes miner: On the basis and manners	of examination	dge, death and/or inv	occurred at estigation, in	the time	e, date and inion, death	d place, a	and due to the ed at the time,	cause(s) and m date and place,	anner es s and due t	stated. the ceuse(s)			
To the	Comple	29b. Signature and title of certifier	eras II	Pm		29c. I	icense	number 100			29d. Date/signe	d (Month,	Day, Year)			
		30. Name and address of person who Inedell W. Inedell	completed cause of art III M	death (Item 23	3a) (Type, F	NIVER	1174	Pho	y	BATM	are m	21	210			
R	State legistrar	31. Dete filed (Month, Day Year) JAN 0 4 20	32. Regis	trar's Signature	5	100	ust	1								

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

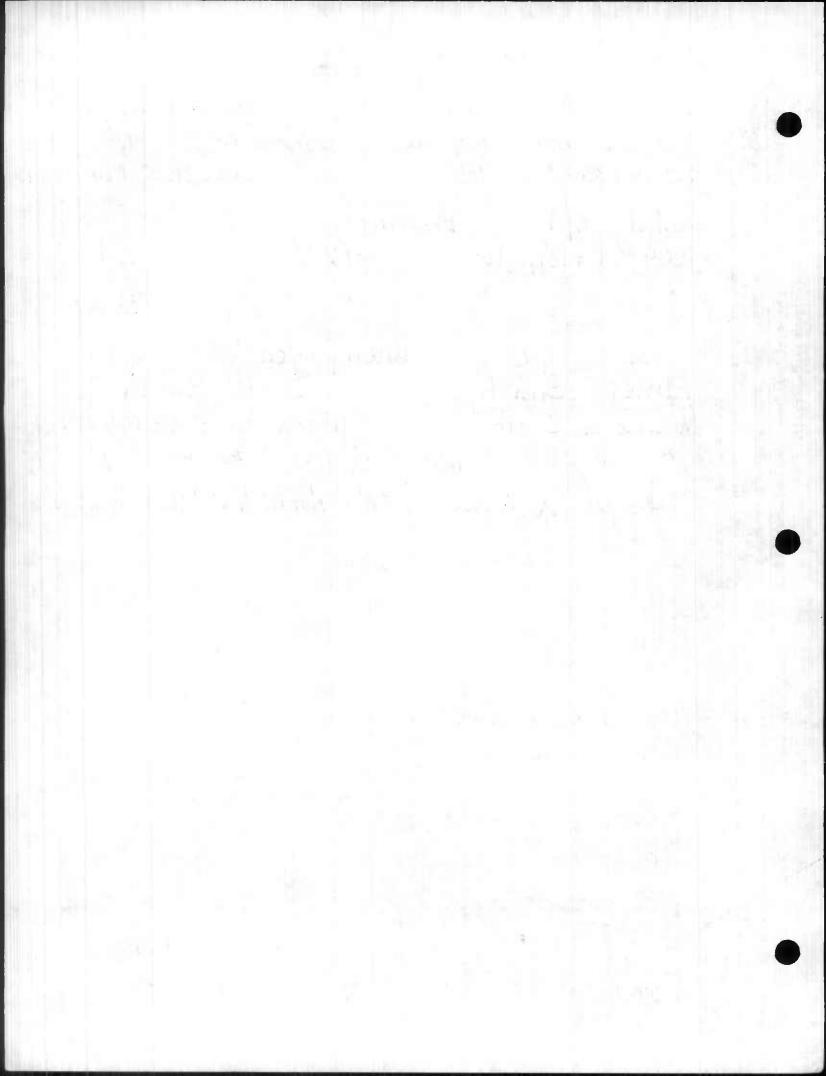
State of Maryland / Department of Health and Mental Hygiene

42340

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle 955pm Month Der 28,2000 **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Deet 4e Fecility Neme (If not institution, give street and number, **Examiner** aryland lei Security Number 7. Age (In Irs. last birthdey) Himore 8. Dete of Birth (Month, Day, If Under 24 Hrs. 9. Birmplece (State or Foreign gountry) **Funeral** 220-64-8330 Usuel Residence of Decedent 1 M 2□ F Months Days Min. Yrs. Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show tian 27 is marked other than "natural", or flams 23a or 28a-f sho other treumstic event, the Madical Examinar must be notified at 1 Yes 2□ No Maryland Directo mor 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 180 ded Funerai Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race American Indien 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced ac Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72. Department of Heelth and Mental Hygiena. Important: If Item 27 is marked other than "na any injury or other treumatic event, the lecture. Elementary/Secondary (0-12) College (1-4or 5+) ove 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be 19a. Informant's Neme/Relationship (Type, Print), (mother) State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 80 alto.1 la. omith Baltlmore, 20b. Plece of Disposition (Na cometery, crematory or 20e. Method of Disposition 20c. Location 1 ■ Burial 2 □ Cremation 3 □ Removal from State 200, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Joseph L. Ru 21. Signature of Funeral Service Licensee Hon North Ave. 212/6 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Exa iner Due to (or es a consequenca of) Physician/Medicai Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequença of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): 23b. Did tobacco use contribute to the causa of death? Part If. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by page 2 should be 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy performed? ours aftar death.

••• Director: After this certificate has filled in by the funaral director, page 2. 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpetient 3□ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 2 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C complately filled the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifiej 2 2 who completed cause of deeth (Item 23a) (Type, Print) land 90 Mary 31. Date filed (Month, Day, Year) 22. Registrer's Signature State 4 200 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:40 PM DECEMBER 29 2000 Rita Lorraine Tuma /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL DINZI If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Days Hours 10 M 200F Yrs. March 22,1921 Maryland 218-18-4516 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 3 No Directo Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 United States 2623 Lynbrook Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 20 No Specify: g 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 yrs. Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie Thomas Coombs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph R. Tuma/ Husband 2623 Lynbrook Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 ☐ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/02/2001 Towson, Maryland Hilltop Service Corp. 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility The Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the dharm shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Onknown CEREBROVASCULER ACCIDENT g 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed BRAdyCARdiA 1 ☐ Yes 2 7 No 1 Yes 2 400 sepsis 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

be executed signed by the attending physician d be detached for use as the buria Box 68760. as the The law requires that the death certificate P.O. of Vital Records. should be this certificate Physician: al or Attending Pi safter death. I Director: After ti d in by the funera Division To the Hospital within 24 hours a To the Funeral C completely filled

Funeral

Director

28a-f show

6 Herne 23a

"natural", or

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should be find Mentel H

7 is marked other traumatic avent, to

permit. Pages 1 and 2 sh Depertment of Heelth end Important: If Itam 27 is m any injury or other trsum page.

Physician /Medical

Examiner

Maryland 21215-0020

KNOWX

ATICNI Baltimore, the Medical Examiner must be notified at

State Registrar COLUARDO FALCON

29b. Signature and title of certified

29a Certifier

edicai

29c. License number RES 000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2000 DECEMBER 29

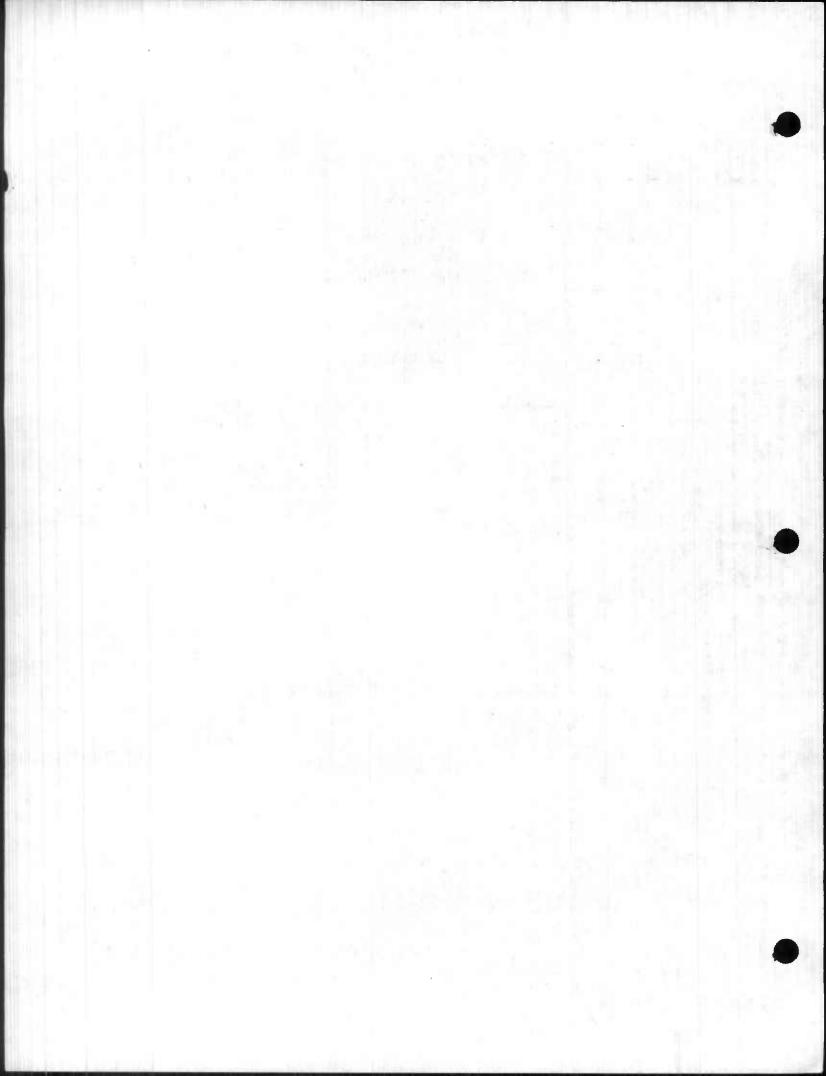
30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401

WEST BELVEDERE, BALTIMORE MODIZIS

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 16 Rev 6/95



00-7482-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. cm State of Maryland / Department of Health and Mental Hygiene Bernadette Thomas amend item 23a, 27, 28a, b, c, de, f per me G791 1/9/01 yf Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month Day Year Physician December 28, Igap 2000 7:46 A.M. /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not Institution, give street and number) 4c. County of Death Examiner Maryland General Hospital Baltimore N/A 8. Dete of Birth Month, Day, 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign **Funeral** 10 M 20 F Months Deys Hours 19-84-0056 Yrs. Director Usuel Residence of Decedent 10a Stete 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo laryland r la marked other than "naturel", or frame 23a or 28e-f i traumatic event, the Wadical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 200 Floor Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Meritel Status Bieck, White, etc. 72 hours after 1 Yes 2 H If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0036 1□ Yes 20 No Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within.
Department of Health and Mental Hygienal importants if from 27 is marked other than any Injury or other traumatic avant Elementary/Secondery (0-12) College (1-4or 5+) OL 0 18. Mother's Neme (First, Middle, Maiden Surneme 17. Father's Neme (First, Middle, Last) Be 70 Intermant's Neme/Reletionship (Type, Pnnt) (5) STET 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, 21 20b. Plece of Disposition (Name of gemetery, cremetery or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Date 10 Burial 2 Cremetion 3 Removel from Stete 2/2001 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Facility
JOSEPH L. RU
2222 W. North ire of Funeral Service License Rus a 1216 North AUR. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) a. NARCOTIC INTOXICATION Examiner Due to (or as e consequence of) Examine certificate be executed attending physician and for use as the burial-tren: Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequença ot): Box 68760. Physician/Medicai Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by I 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. ğ 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed peed completion of cause of death? The lew page 2 s certificate has 2 No Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1☐XYes 2☐ No 1 Inpatient 3 DOA 2 ₩ ER/Outpetient After this unknown 28a. Dete of Injury (Month, Dey 12/28/00 28b. Time of 28d. Describe how injury occurred 27. Menner of Deeth Certification: 1 Neturel 5 Pending investigation unknown 1 Yes 2 No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rutel Route Number, City or Town, State) 2031 Druid Hill Ave., Baltimore, Md 28e. Pleca of Injury - At home, term, street, factory, office building, etc. (Specify) home filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Complataly filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end manner steted. edicai 29d. Date signed (Month, Dey, Year) 29c. License number 29b/Signal O.C.M.E. December 29, 2000

State Registrar

DHMH 16 Rev 6/95

and address of person who completed common of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 M 31. Dete filed (Month, Dey, Year) JAN 04 200

32. Registrer's Signeture

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42343 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yee Month **Physician** Robert Hugh Watson December 27 2000 11:05 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mariner Health of Forest Hill Forest Hill Harford If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months Devs Hours 1ÑM 2□ F 705-07-9271 October 22,1907 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c City Town or Location 10d. Inside City Limits Harford Forest Hill 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 109 Forest Valley Drive 10g. Citizen of What Country? 10f. Zip Code 21050 United States Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? t 4. Race - American Indien, 11. Maritel Status Bleck, White, etc. 1 Yes 2/2/No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Specify: White 1 Yes 2 No Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Cotlege (1-4or 5+) Machinist Railroad 0 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be unknown Edwin Watson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Marjorie Pence/Daughter in Law 3209 Green Road, Whitehall, Maryland, 21161 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Loudon Park Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 01/04/01 Baltimore, Maryland 22. Name and Address of Fecility 21. Signeture of Funeral Service Licenses Hubbard Funeral Home, Inc. 23a. Pert Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest,

Approximate

Approximate Approximete Intervel Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, If eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner Box 68760. Physician/Medical P.O. Records. by Completed Division of Vitai or Attending Physician: Be Certification: To After this deeth. within 24 hours after deel To the Funeral Director: filled in by Hospital

Funeral

Director

r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at

of the end Mental Hygiene.

27 Is marked other than "r treumatic event, the Mental than "r

permit. Pages 1 and 2 should be file Department of Heelth end Mental Hy Important: If Nem 27 is marked other eny Injury or other treumatic event.

Physician /Medical

Examiner

filed within 72 hours after death

21215-0020

Baltimore, Maryland

Medical completely the the Registrar

(Month, Day, Year) N 0 4 200

29b. Signeture and title of certifier

29e. Certifier

(Check only one)

VALACAO HARFORD RD SU 106 FALLSTONHD21047 1716 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

M.D.

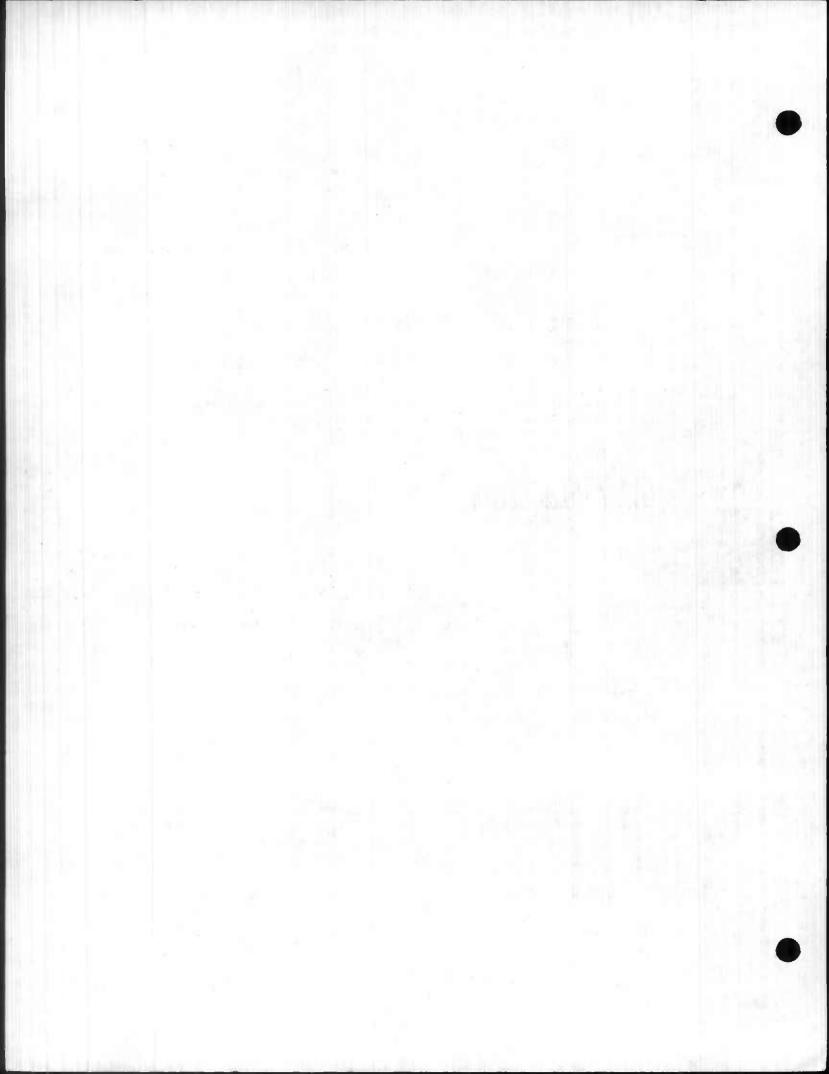
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0016389

29d. Date signed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Vear **Physician** 6.50 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) Examiner 7. Age In yrs. last birthday) If Under 1 Year Months Deys If Under 24 Hrs 9. Birthplace (State or Foreign Country) 5. Sociel Security Number 6 Sex 8. Dete of Birth (Month, Day, Year) **Funeral** 10M 20F Houra Director Usual Residence of Decedan with the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Maryland 10e. Street and Number Director 10f. Zip Code 10g. Citizen of What Country? I is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 21206 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Stetus Bleck, White, etc. 1 □ Never Married 2 □ Merried Specify: Blac 1 Yes 2 No Specify p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within ind Mentel Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) 18. Mother's Neme (First, Middle, Maiden Sumeme, 17. Father's Neme (First, Middle, Last) and Mentel 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) of Health & Maryland 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, State Important: If it any injury or 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State letro 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 21229 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examine: Physician/Medical Examiner The lew requires that the death certificate be axecuted Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last attending physician and for use as the burial-tran Due to (or es e consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed ate has b 1 ☐ Yes 2 ☐ No 1 Yes director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitet: 30 No 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient Nursing Home 3 DOA 5 Residence 6 Other (Specify) 27. Mengler of Deet 1 Neturat 2 Accident Certification: 28e. Dete of Injury (Month, Dey Year) Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 5 Pending investigation 1 Yes 2 No death. Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide aftar within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number

State Registrar

Division of Vital Records, P.O. Box 68760

31. Dete fited (Month, Day, Year)

JAN 0 4 2001

Coymond

NZE. MO 7 32. Registrer's Signeture

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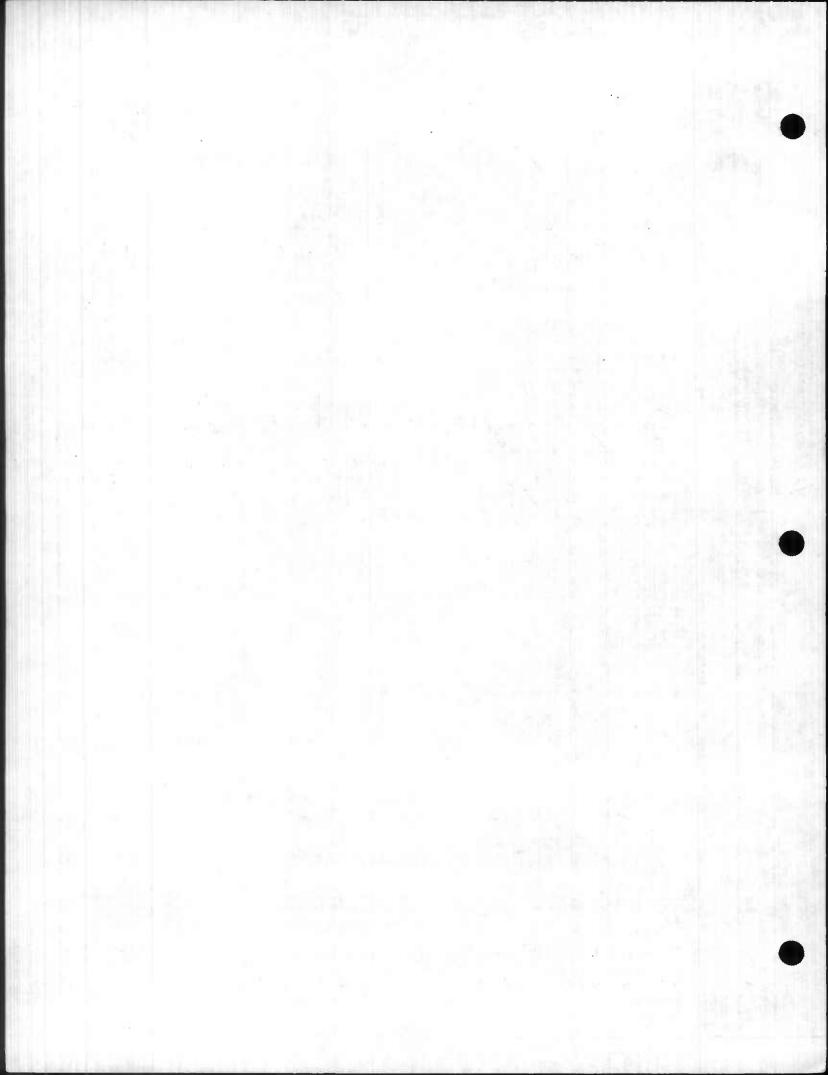
30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Sparks

ORIGINAL

YORK

#100



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Items#16a-b,17,18,19b-c,20b-c perFHG791 1/10/01 EW Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 2:30 Am wolf Cues 4 2000 12 13 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner KIVERVIEW CARE ESSEX CENTER Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 10M 20 F 71 Yrs. 232-40-1473 Dec 19, 1928 West Virginia Usual Residence of Decedent 10b. County Baltimore 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yas 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Baltimore, MD One Eastern Blvd Funeral 21221 14. Raca - American Indian, 12. Was Decedant Ever in U,S. Armed Forces?
1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) unk Black, White, etc. 1 Never Marriad 2 Married 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

House Vocabor 16b. Kind of Business/Industry House Keeper Elementary/Secondary (0-12) College (1-4or 5+) Alliance Corp unk disabled 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Surname) Be - Earl Walker Thetus Earl Walker Laura Wolf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Martha McKean/neice 100 N. Philadelphia Blvd Apt 3 Aberdeen, Md 21001 20b. Placa of Disposition (Name of cematery, cramatory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) in state Cheseapeake Crematory Beltsville, Md 1/13/01 4 ☐ Donation 5 🖾 Other (Specify) 21. Signature of Funeral Strujce Licensee Ronald S. Wade, Director 22 Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Willer 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat end Death Pew dan Immediate Cause (Final disease or condition resulting in death) epsis Due to (or as a consequenca of): Examiner toes whe. Dua to (or as a consequenca of): years. eripheral

Physician /Medical **Examiner**

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Merylen Department of Health and Mentel Hydens. Important: If them 27 is marked other than "naturel; or items 23s or 28s-f show any Injury or other treumatic event, the Medical Examples mystillad at 2006.

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records.

sicien end burial-transit attending physicien for use as the bung edicai Physician/M deteched es been signed by 2 should be detec g Completed pege Be Lo Certification:

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this certificate has

of after deeth.

Director: After 1

To the Hospital of within 24 hours at To the Funeral D completely filled in

Medical

Uprecela Due to (or as a consequence of) years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 thinknown Hyportees. un

Tobacco use

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

1 Yas 2 No

Schizophrauin 25. Was case referred to medical examiner? 1 Yas 2 No

26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify)

1 Yes 2 No

27. Manner of Death Natural 5 Pending investigation 2 Accident 3 ☐ Suicida

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) **fnjury**

28d. Describe how injury occurred 1 Yes 2 No

6 Could not be determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifler

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

(Check only one) 29b. Signatura and titla of certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

lilearl busance 30. Nama and address of perso namho completed cause of death (Item 23a) (Type, Print)

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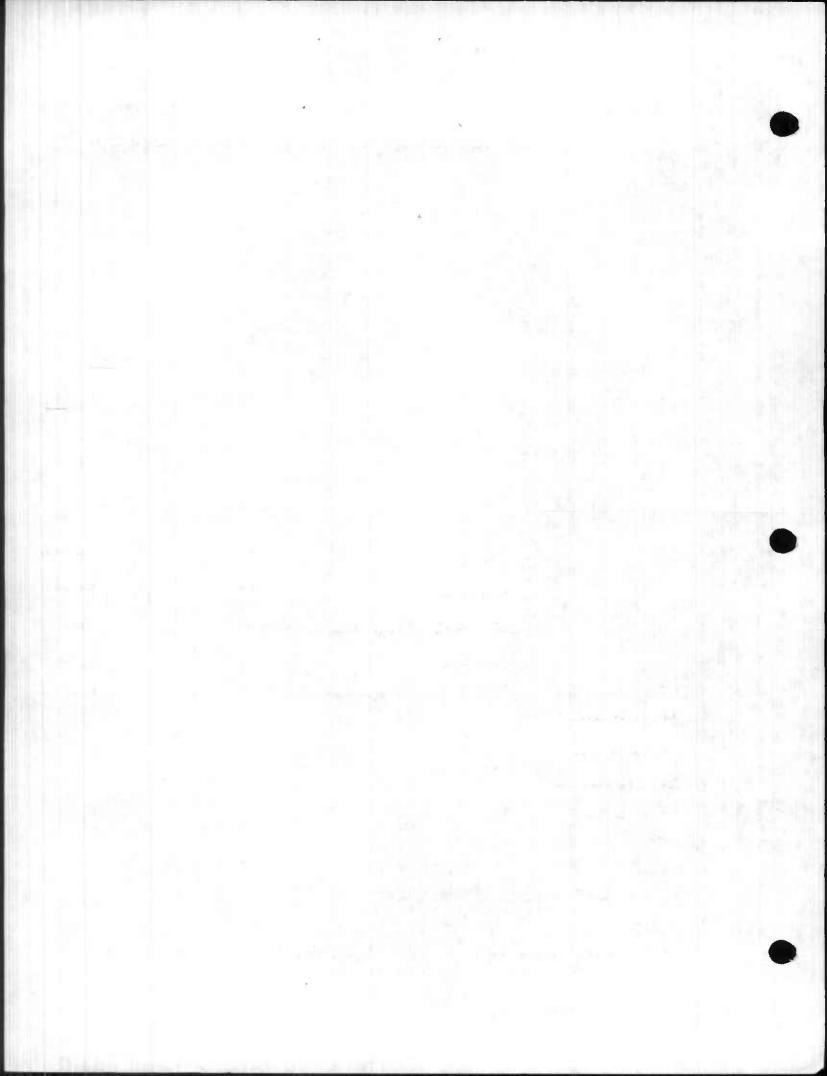
12-14-2000

Michael H. Schwartz 31. Date filed (Month, Day, Year)

Riverview Care Center 32. Registrar's Signature

works

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 42346 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death WARREN **Physician** FANNIE 2022 DECEMBEL 272000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALTIMORE CIN JOHNS TAL If Under 1 NA HUPKINS HOSPI 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) **Funeral** 1□M 2□F Months Deys Hours Min. 578-20-1085 88 Yrs. 08-25-12 VA Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits X1 Yas 2 No MD Baltimore 10e. Streef and Number 10f. Zip Coda 10g. Citizen of What Counfry? 늄 or items 23s or uniner must be r 21213 1816 E. North Avenue USA Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marifal Stafus 1 Yes 2 No It Yes, Give X Year or Dates: 1 Nevar Merried 2 Married 1□ Yes 2□No à 3 Widowed 4 □ Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Co. 12th Grade Manager 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be et bluode Mental George W. Taylor Sarah Johnson 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21239 19a. Informent's Neme/Reletionship (Type, Print) 1 and 2 f Health flam 27 i Sylvia T. Turner 1745 E. Northern Parkway Baltimore, Md. Saltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata Pages 1 Muriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Nat'l Mem Cem. 01-02-01 Laurel, MD MD. 21. Signeture of Funerel Service Licenses 22. Nama end Address of Fecility Baltimore, Maryland 21202 la Warre WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) Sepsis /Medical 40055 Examiner Due to (or es a consequence of): staphyloco ccus Examiner 4005 aureus the death certificate be assecuted attending physician and for use es the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ρ 24b. Were eutopsy findings aveilable prior to completion of causa of death? been si 24a. Was an autopsy Completed hes he 2 certificete her 1 Yes 2 No 1 Yes 2 No Physician: 25. Wes cese reterred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Injury et Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Neturel death. 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) after 4 Homicide hin 24 hours a the Funeral C npletely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated. edicai 29e. Certifier To the P within 2. To the P 29d. Date signed (Month, Day, Year) 29b. Signature and fitte of certifier 29c. License number 6. Min m RES-000 PHYSICIAN

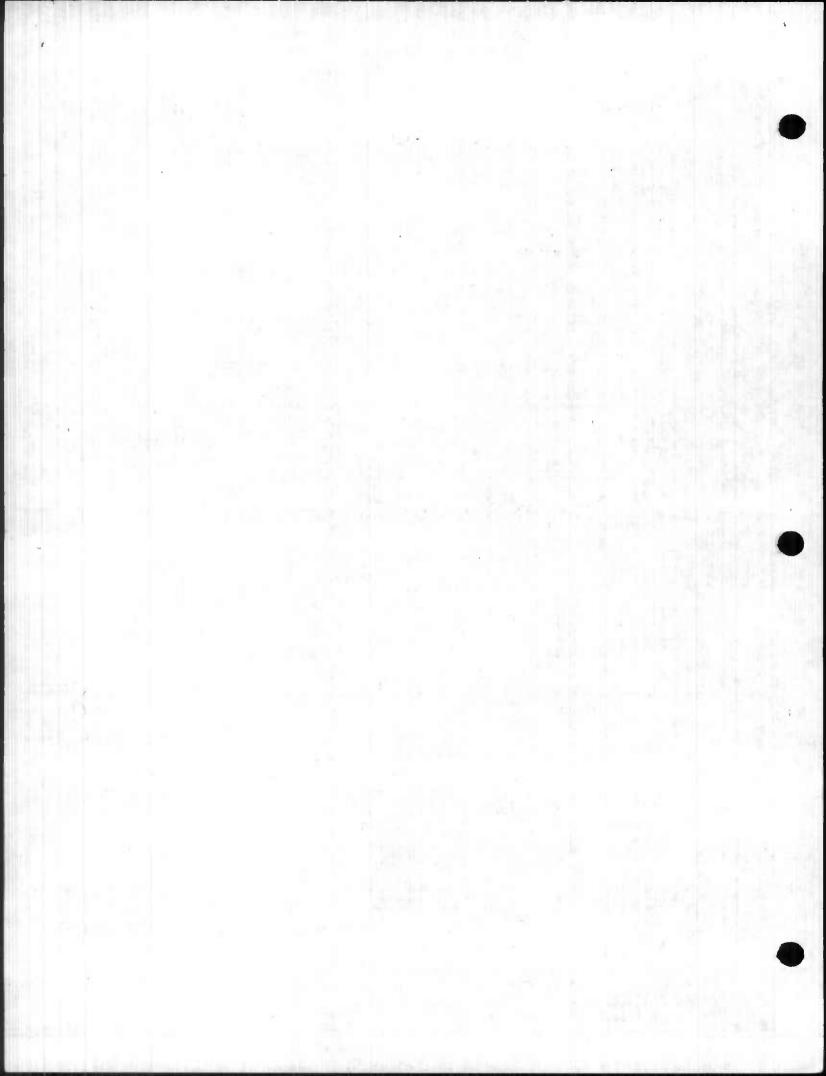
Registrar

31. Dete filed (Month, Dey, Year) JAN U 4 2001 32. Registrer's Signeture

DECEMBER 27, 2000

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

SHANNON J. WINAKUR, MO; JOHNS HOPKINS HOSPITAL; BALTIMORE, MARYLAND



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death whipps 2 Per Eugene Dec 2000 6:00 PM 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Death Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) 10 M 2 F Deys Yrs. 219-10-1425 Sept.8,1923 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Howard Jessup Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7734 Washington Blvd. Trailer 66 21075 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No
If Yes, Give
Yaer or Dates: 143-145 1 Never Merried 2 Married 1 Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade complated) General Conference Esda/Sales Elementery/Secondary (0-12) College (1-4or 5+) Shipping Clerk 10 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Eva Tyler Pattison Whipps 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5900 Maple Terrace Laurel, Maryland 20707 Elizabeth Rice / granddaughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 XCremetion 3 ☐ Removel from State Jan.4, Balt./Wash. Crematory Laurel, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Fleck Funeral Home, Inc. 23a. Parl. Enter the disease, or complications het causad tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one causa on each line. 7601 Sandy Spring Road Laurel, Maryland 20707 Approximate Interval Between Onset and Death Immedieta Ceuse (Final disaesa or condition resulting in deeth) 2 weeks Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown Sensis 24b. Were eutopsy findings evailable prior to complation of cause of deeth? 24e. Wes an eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case raferred to medical 26. Placa of Death (Check only one) Hospitel: 12 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Death 5 Pending investigation 1 Metural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and menner stated. 29a Certifier

29c. License number

D37013

Little Paturent Plany

29d. Date signed (Month, Dey, Year)

Colymbia

/Medical Examiner The law requires that the death certificate be executed Box 68760. P.O. of Vital Records. or Attending Physician: after death. Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Al completely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

items 23s or 28s-f show

*natural', or

al Hygiene.

Pages 1 and 2 should be nant of Health and Mental ant: If Item 27 is marked o

permit. Pages 1 and 2: Department of Health at Important: if Item 27 ie any injury or other transponce.

Physician

as the bunal-tran

this certificate has been sirral director, page 2 should

After

Physician/Medical Examiner

by

Be Completed

2

Medical Certification:

filed within 72 hours after death

Maryland 21215-0020

Baltimore,

the Medical Examiner must be notified at

Director

Funeral

by

Completed

DHMH 16 Rev 6/95

Registrar

Conger 31. Dete filed (Month, Dey, Year) JAN 0 4 2001

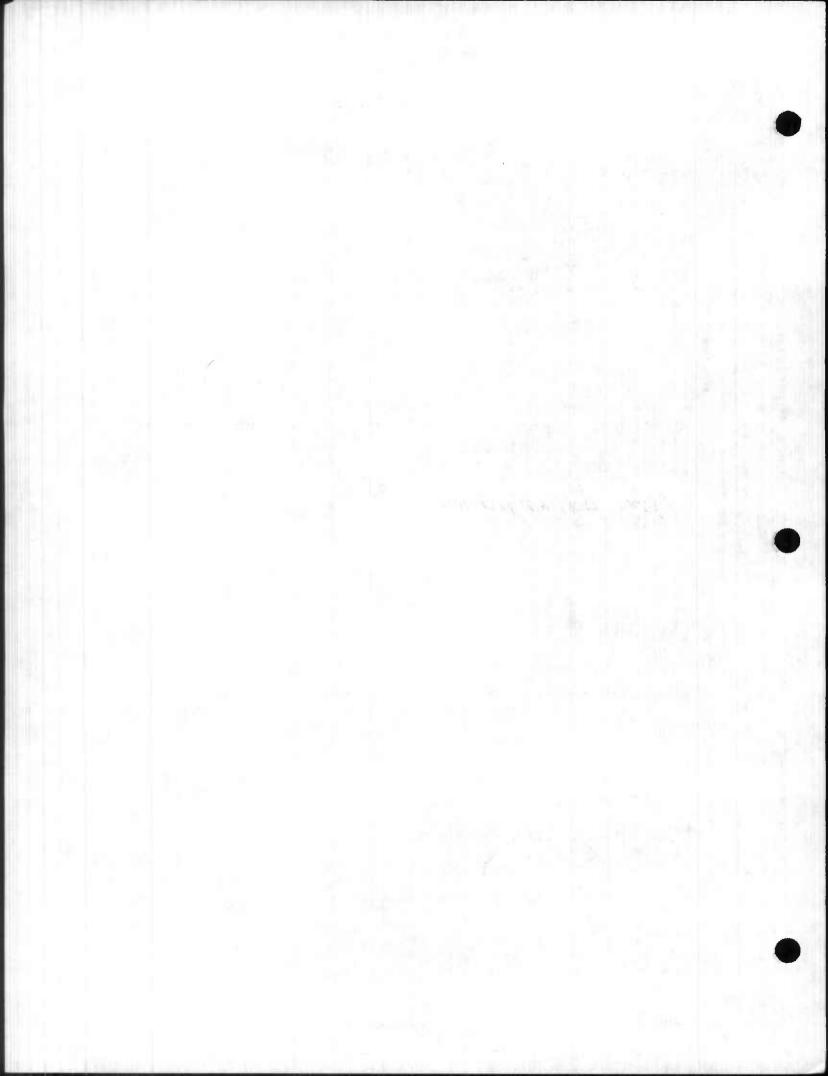
29b. Signature and title of certifier

40

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

205, 11055 32. Registrer's Signeture

Mp Intures



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 23:25 PM WENGERT [DWARD 26,2000 Deamber /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE, MO BATTIMORE CITY HOSPITAL LENTER HARBOR 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplace (Stata or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1⊠M 2□ F Yrs. 216 03 8570 85 Maryland Aug. 12, 1915 Director Usual Rasidence of Decedent 10d. Insida City Limits 10a Stata 10b. County 10c. City, Town or Location 1 ☐ Yas 2 € No Maryland Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 822 Holly Drive 21401 U.S. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - Amarican Indian. 11 Marital Status Black, White, atc. 1 ☐ Yas 2 📆 No If Yas, Giva Yaar or Datas: 1 □ Nevar Married 257 Married Saltimore, Maryland 21215-0020 3 1 Yas 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Foreman Machine Shop 12th 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Pages 1 and 2 should be fit threat of Health and Mental H tent: If flest 27 is marked off jury or other traumatic ever (Not available) Mary Viscoseal Wengert 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Rose Wengert Wife 822 Holly Drive Annapolis, Maryland 21401 20b. Place of Disposition (Nama of cematery, cramatory or other place) Data 20c. Location - City or Town, Stata 20a Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 12/30/00 Baltimore, Maryland Gardens of Faith Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licensing Gonce Funeral Home P.A. ramusus 4001 Ritchie Highway Baltimore, Md. 23a. Part1. Enter the disease, or complete irons that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician Immediate Cause (Final disaasa or condition rasulting in death) /Medical P. ENAL CELL YEARS Examiner Dua to (or as a consequence of) Physician/Medical Examiner inknown ULMONARY Sequentially list conditions, if any, laading to immediata ceusa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequance of) Box 68760. Lhown Dua to (or as a consequence of) un known RESPIRATORY FAILURB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown RENAL FAILURE MEONIC Records. þ 24b. Ware autopsy findings 24a. Was an autopsy Completed available prior to completion of ceusa of death? BILATERAL PREUMONIA 1 Yes 20 No 1 Yas 2 No bleeding Division of Vital or Attending Physician: 25. Was cesa referred to medical axaminar? Be 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Matural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 TYes 2 □ No invastigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 ☐ Homicide edical 1 Certifying Physician: To tha best of my knowledga, daath occurred et the time, dete end plece, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian RES 000 VecombER 30. Nama and eddress of person who completed cause of death (Item 23a) (Type, Print) HAR BOR HOSP; TAL

Registrar DHMH 16 Rev 6/95

M

32. Registrar's Signatura

GALABOV

31. Data filed (Month, Day, Year)
JAN 0 4 2001

3001 S. HANOVER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dev Month Vaer **Physician** Irvina Weiner December 31, 2000 4:05 PM /Medical 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner HOSPICE OF BALTIMORE-GILCHRIST CENTER BALTIMORE BALTIMORE If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year, NOV 1 1923 5. Social Security Number 6. Sax 1 M 2 □ F 7. Age (In vrs. lest birthday) If Under 1 Year 9. Birthplaca (State or Foreign **Funeral** Deys Hours 098-16-1886 77 BROOKLYN, NY Director Usuel Rasidence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "vatural", or items 23e or 23e-f show traumetic event, the Medical Examinar must be notified at N/A XX Yes 2 No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Coda 2907 FALLSTAFF ROAD #T5 21209 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yas 2 ☑ No
If Yes, Give
Year or Detes: 14. Race - Amarican Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecificHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired)

OPTICIAN parmit. Pages 1 and 2 should be fitted within 72. Department of Health and Mental Hygiene. Importants if filen 27 is marked other than "ratio any injury or other traumatic event, the Made-appears. 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (124or 5+) OPTICAL 18. Mother's Nama (First, Middla, Maiden Sumeme) 17. Fathar's Name (First, Middla, Last) 88 REUBEN WEINER FRIEDA STECKLER 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
BERNICE WEINER/WIFE 2907 FALLSTAFF ROAD #T5 BALTIMORE, MD. 21209 20b. Place of Disposition (Neme of camatary, crametory or other pleca) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 5 ☐ Other (Specify) Beth Tfiloh Congregation 1/1/01 Woodlawn, Maryland 4 Donation 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 Part Enter the disease, or compiler snock, or naen failure. List only one a et causad the death. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximete Intervel Between Onset end Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in deeth) Pneumonia Examiner Due to (or es e consequenca of): Examiner The law requires that the death certificate be executed physicien and the burial-trensit Sequentially list conditions, if any, leeding to immediate causa. Entar Underlying Cause (Disaese or Injury thet initiated evants rasulting in death) Last Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 80 guipuette 950 signed by the a Part II. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown by 24b. Were eutopsy findings aveilable prior to 24a. Was an autopsy performed? Completed peen s completion of causa of deeth? page 2 s certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Wes casa rafarred to medical Be 26. Place of Deeth (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 24 hours after deeth.

Funeral Director: After this delety filled in by the funeral director. 28e. Data of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: or Attending 1 Watural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, offica building, atc. (Specify) 4 Homlcide Hospital 29a. Cartifiar 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, dete end place, end due to the ceuse(s) end manner as stated edicai sompletely (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, dete end pleca, and due to the ceuse(s) end mennar stated. within 2 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier 30. Nema and addrass of person who complated causa of daath (Item 23a) (Type, Print) Pikesville Old 31. Date filed (Month, Day," Year) 32. Registrer's Signature

State Registrar

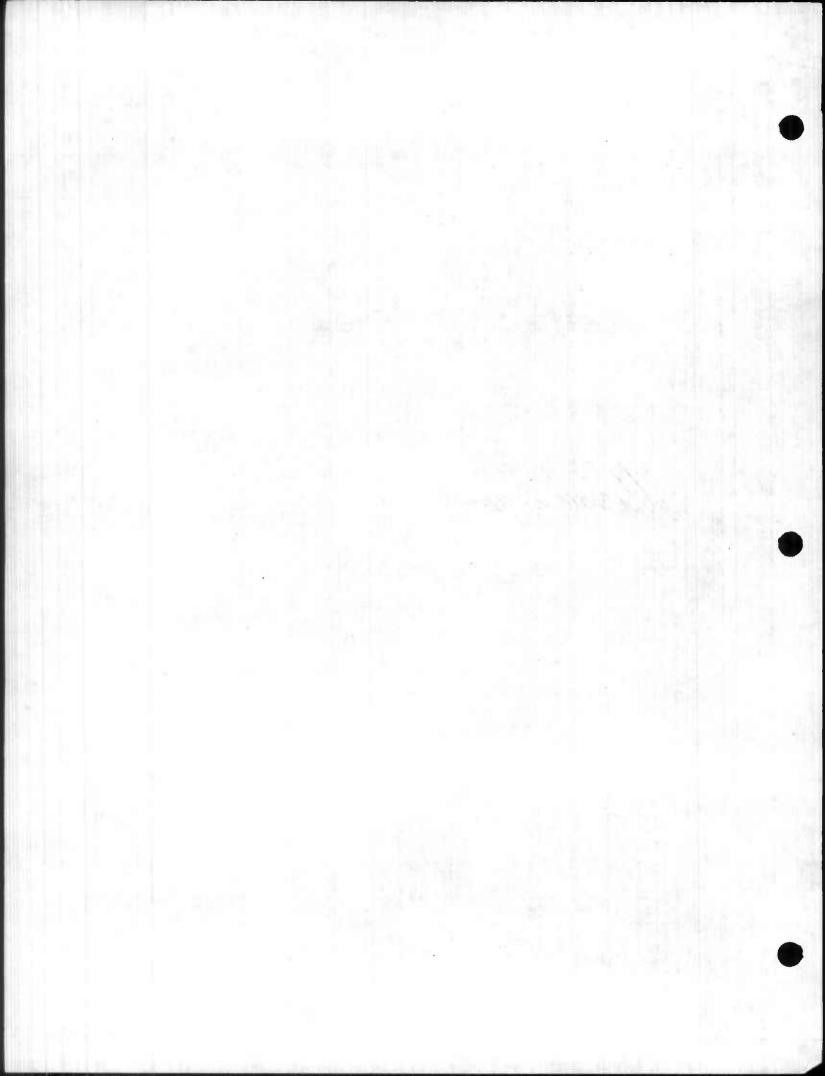
DHMH 16 Rev 6/95

ORIGINAL

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1 Carks



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** 2000 /Medical 4a Facility Nama (If not institution, giva street and 4b. City, Town, or Location of Death 4c. County of Death Examiner allstown enesi ar 7. Aga (In yrs. last birthday)
Yrs. 5. Social Security Number 6 Sex **Funeral** 1□M 200 F Months Days Hours III-10-1346 Usuai Rasidance of Decedant Director with the Maryland in and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, ma Medical Examinar must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1X Yas 2 No Director Varyland mor 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2121 ac Funeral permit. Peges 1 and 2 ahould be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23, any Injury or other traumatic avent, tha Med 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Maritai Status Black, Whita, atc. 1 □ Nevar Married 2 □ Married 1 Yas 2 No Specify þ 3 Widowad 4 Divorced Hmerican Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla. ar 19a. Informant's Name/Relationship (Type, Print) Community (F) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, d. 21207 Grown 10, 20a. Method of Dispositio 20b. Place of Disposition (Nama of cematary, cramatory or other place 1 ⊠ Burial 2 □ Cremation 3 DRamoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 100 22. Name and Address of Facility
Joseph L. Ru ire of Funeral Service Lidenses Ave. W. North 2222 Approximata interval Batween Onsat and Death Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequance of): D Box 68760. Dua to (or as a consequance of) signed by the aid to be detached for 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of causa of death? been sig 24a. Was an autopsy performed? Completed page 2 s r this certificate ? 1 Yas 1 ☐ Yas 2 ☐ No or Attanding Physician: 25. Was casa ratarred to medical axaminar? Be 26. Placa of Death (Check only one) 20 No 2 1 Yas 1 Inpatient 3 DOA 40 Nursing Homa 2 ER/Outpatient 5 ☐ Rasidence 6 ☐ Othar (Specify) 27. Mannar of Death 1 Natural 2 Accidant Certification: Date of injury (Month, Day Year) injury at Work? 28d. Describe how injury occurred After 5 Panding invastigation deeth. 1 Yas 2 - No To the Hospital or Atlandis within 24 hours after deeth. To the Funeral Director; Al completely filled in by the fu 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. edicai 29a, Cartifier (Check only one) 29b. Signature and afte of certified 29c. Licensa number Ce m 30. Name and aderass of person who completed cause of death (item 23a) (Type, Print) RAYMOND F. CAPLAN GENESIS EDLERCARE 31. Data filed (Month, Day, Year)

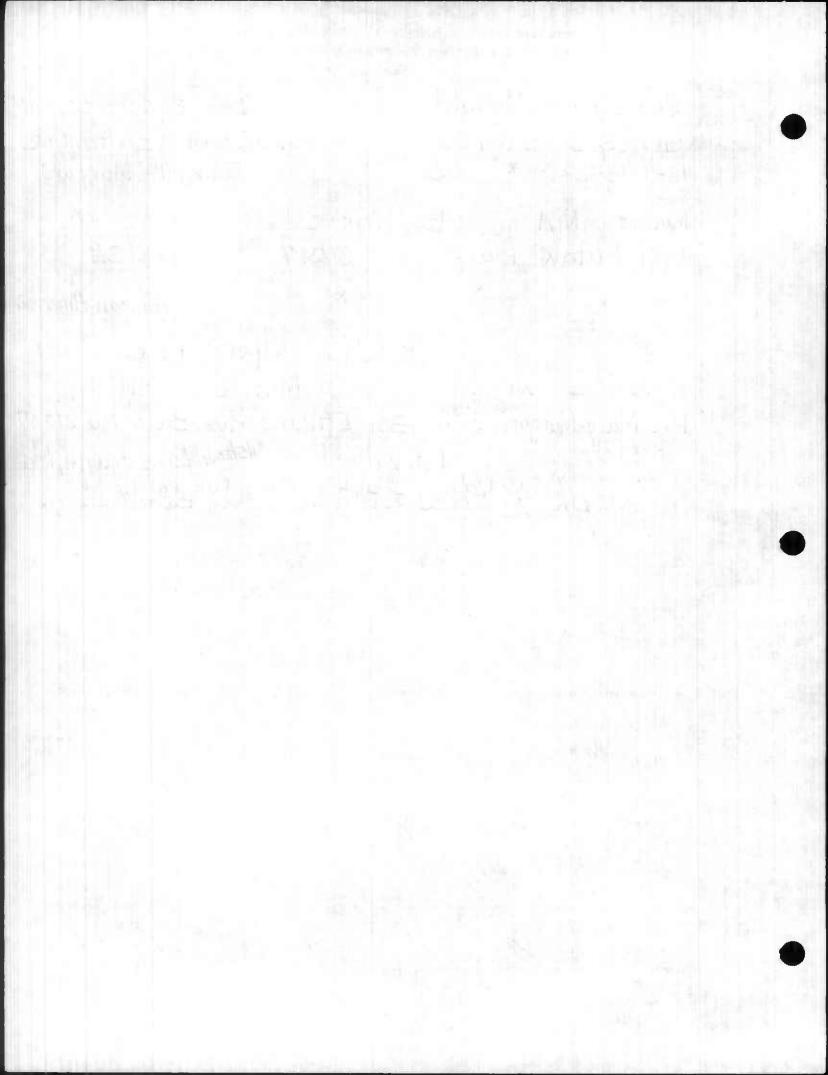
DHMH 16 Rev 6/95

State

Registrar

JAN

32. Registrar's Signatura



Division of Vital or Attending Physician: After this funeral dir Certification: death. Director: / within 24 hours eff To the Funeral Di completely filled in Hospital edicai To the

Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, Ierm, street, lactory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier Cluston 29c. License number

29d. Date signed (Month, Dey, Year)

OCME

DECEMBER 27, 2000

30. Neme and address of person who completed ceuse of death (Item 23e) (Typa, Print)

Venno Chute 31. Date filed (Month, Day, Year)

32. Registrar's Signeture 111 Penn Street, Baltimore, Maryland 21201

State Registrar

JAN 0 4 2001

ORIGINAL

Plea

Please T	ype or Print In B							ble. 42352
			ertificate				eg. No.	46006
1. Decedant'a Nama (First, Middla, Last)	A INIO ENEV					2. Data of Dea Month	th Day	3. Tima of Death
Ruby Parce	11 Ash					December	24, 2	000 10:30 a.m.
4a Facility Nama (If not institution, giva s	CONTRACTOR OF THE PROPERTY OF					r Location of Death	4c. County	
St. Mary's Nurs 5. Social Sacurity Number 6. Sax		lact hirtho	(av) If Undar	1 Yaar	Leonard		St. M.	-
	M 2 ■ F 87	Yrs	Months	Days	Hours Mi	n. (Month, Day	Year)	9. Birthplaca (Stata or Foraign Country) Virginia
10a. Stata 10b. County	10c. City	y, Town o	r Location					10d. Inside City Limits
Maryland St. Ma	ry's Lec	onard	ltown					1 ■ Yas 2 □ No
10e. Street and Number			10f. Zip	Coda		1	0g. Citizen of V	Vhet Country?
21585 Peabody Stre			10.111		0650		United	States e - Amarican Indian,
11. Marital Status 1 Nevar Married 2 Married	12. Was Dacedant Evar in U, Armed Forcas? 1 ☐ Yas 2 ☐ No	,5.	If Yas, spec	ify Cub	ean, Maxican, Pus	(Specify Yas or No- arto Rican, atc.)		ek, Whita, atc.
3 Widowad 4 Divorced	If Yas, Giva Yaar or Datas:		1□ Yas 2	2 No	Specify:		Specify	White
15. Decedant's Educ (Specify only highast grade		10	ecedant's Usua Siva kind of wor	rk dona	during most of w	vorking	16b. Kind of Bu	usinass/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		fe. DO NOT us	se retire	od)			
17. Fathar's Nama (First, Middla, Last)		Home	emaker		18 Mothar's N	lama (First, Middla,	Own H Maidan Sumam	
David Allen Parcel	1				Ada Is	abell Wil	liams	
19a. Informant's Name/Relationship (Type	oe, Print)	19b. N	failing Addrass	(Stree		Rural Routa Number		Stata, Zip Coda)
1 Burial 2 Cramation 3 S. A. 4 Donetion 5 Othar (Specify) 21. Sign 1 Structure S. Control S. Section 1 Section 1 Section 1 Section 1 Section 1 Section 23a. Part. Entar tha disaasa, or complication 23a. Part. Entar tha disaasa, or complication 25a. Part. Entar tha disaasa, or complication 25a. Part. Entar that disaasa, or complication 25a. Part. Entar	cations that causad tha death a causa on each line. Due to (or	no not no not no not not not not not not	22. Nama and 229.55 and antar the model of t	ial d Addr Hol. a of dy	Gardens ass of Facility B Lywood R ng, such as card	rinsfield oad, Leona iac or raspiratory arr	Funerardtown,	Approximata Interval Batween Onset and Death ntribute to the cause of death? 3 Probably 4 Punknown
						24a. Was a		24b. Ware autopsy findings availabla prior to completion of causa of daath?
						1 🗆 Y	es 2 No	1 ☐ Yes 2 ☐ No
25. Was casa rafarrad to medical examiner?					26. Placa of D	eath (Check only or	na)	
1 Yes 2 No H 27. Mannar of Death 1 Natural 5 Panding invastigation	ospital: 1 Inpatiant 2 28e. Data of Injury (Month, Day Year)	ER/Outpo 28b. Tim Inju	ne of 2	8c. Inju	-	Home 5 Resid		
3 Suicida 6 Could not be datarminad	28a. Place of Injury - At ho building, atc. (Spacify	oma, farm	, straat, factory	, office		28f. Location (S City or Tow		per or Rural Routa Number,
	ician: To tha best of my knov er: On tha basis of axaminat and mannar stated.		or Invastigation,	, In my		curred at tha tima, o	ata and place,	

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Haalth and Mantal Hyglene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-4 show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral Director

Director

Funeral

by

Completed

Be

10

Examiner been signed by the attending physician and should be detached for use es the bunal-transit Physician/Medical by Completed page 2 should Be Medical Certification: To

The law requires that the death certificate be axecuted To the Hospital or Attending Physician: The law within 24 hours efter death.

To the Funeral Director: After this certificate hes tely filled in by the funaral director,

Division of Vital Records, P.O. Box 68760,

State Registrar

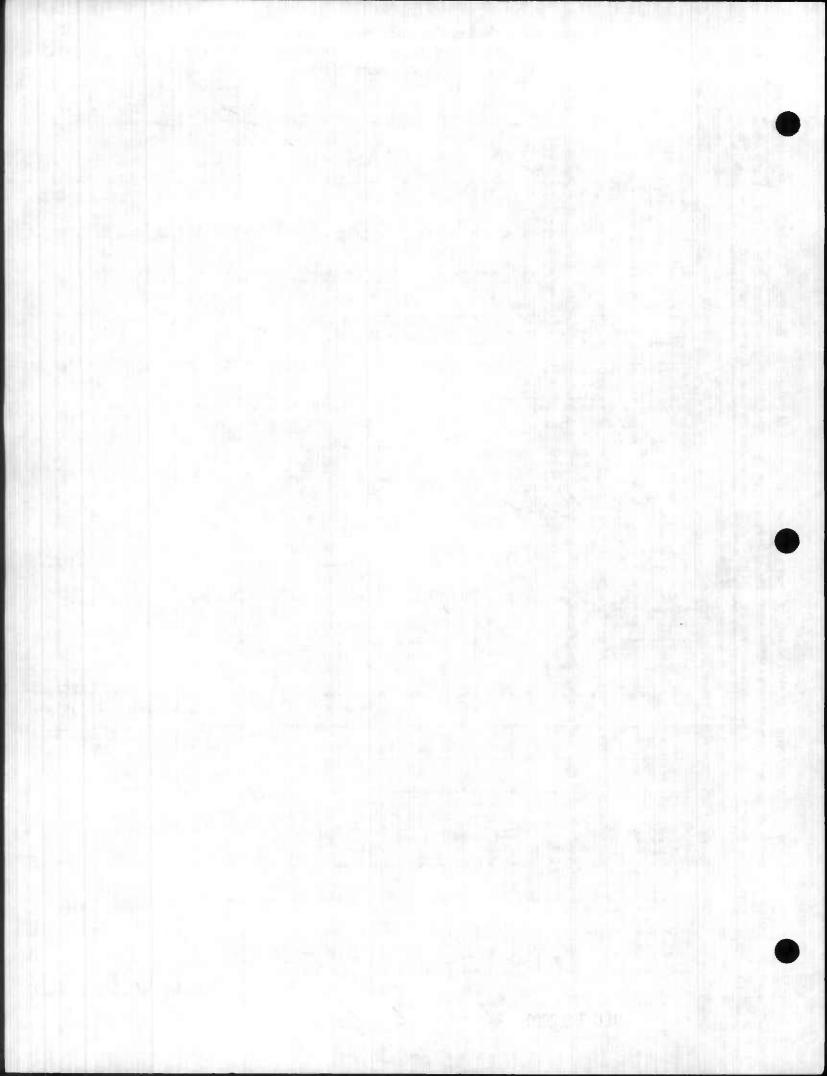
Patrick Jarbod, M.D., 24035Three Notch Road, Hollywood, Maryland 20636 31. Date files (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 42353

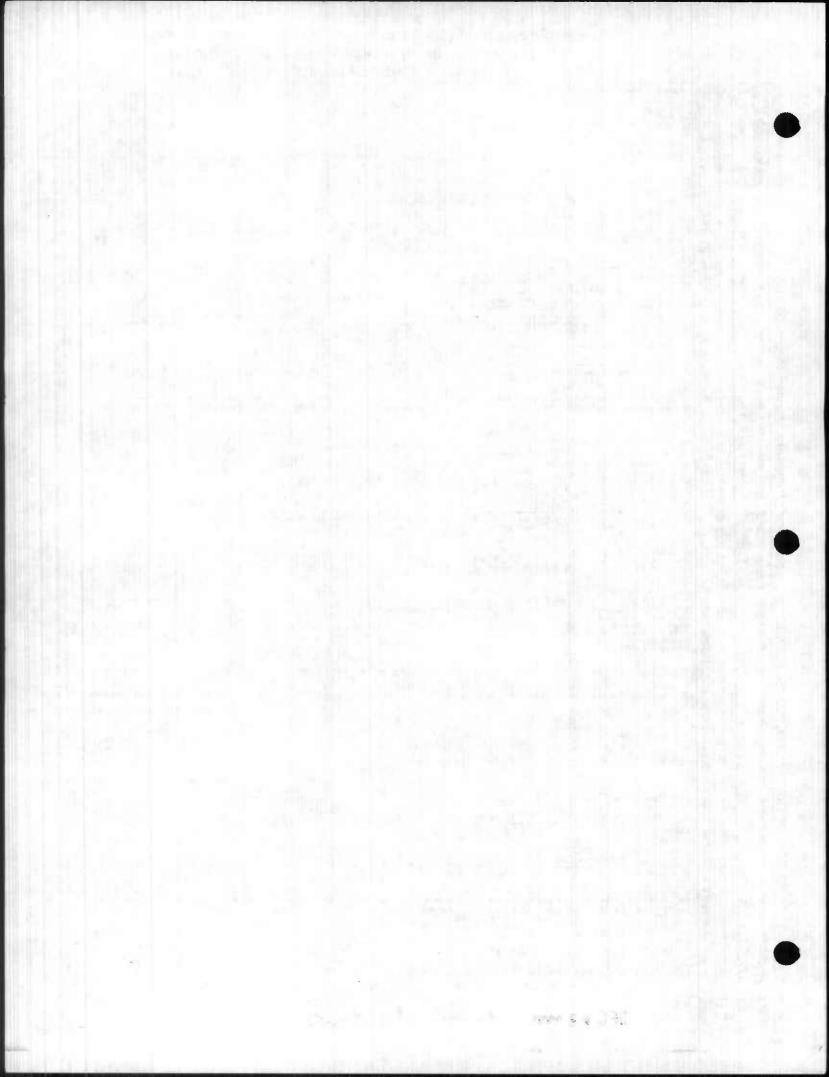
			Certific	ate of D	eath	R	eg. No.				
-	1. Decedant'a Nama (First, Middla, La	st)				2. Dete of Dea		3. Time of D	eath		
Physician	TOSEPH JUHN AZ	Month Decembe		1000 2:45	-Am						
/Medica Examine	to Capility Name /// not institution six	4c. County o									
Examine	Carroll County General Hospital Westminster Carroll										
Funeral	5 Social Security Number 6 Sev 7 Ace (In use fact high-day) If Under 1 Year If Under 24 Hrs. 9 Date of Right										
Director	214-01-9204 Usual Rasidence of Decedent	₩ 2□ F	87 Yrs. Mont	hs Days	Hours Min	Feb. 14		9. Birthplace (Steta or Country) Maryland			
D Bu	10a. Stata 10b. County	10c. C	ity, Town or Location			-		10d. Inside City	Limits		
ar death with the Maryla terns 23e or 28e-f shon ner mast be notified at	Maryland Carrol	1	New Windso		7.	(1 ☐ Yas 2	2□No X		
10 to	10e. Street and Number		10f.	Zip Code			10g. Citizan of What Country?				
23a 9 w	1400 Wakefield Va	lley Road		2177	6		United	States			
har dea	11. Merital Status	12. Was Decedent Evar in 1 Armed Forcas?	J,S. 13. Was Da	cedent of His	penic Orlgin? (Specify Yas or No- rto Rican, atc.)		- Amarican Indian, , Whita, atc.			
21215-0020 d within 72 hours after gene. than 'neatural', or it the Medical Examin		1 Yas 2 No If Yas, Giva Yaar or Detas:	_		Specify:		Specify: White				
9 2 10 1	15. Decedant's Ed		16a. Decedant's L	Isuel Occupat	ion		16b. Kind of Bus				
21215-0 ad within 72 ho spiens. er than 'netur t, the Medical	(Specify only highast gra	Collega (1-4or 5+)	(Giva kind of lifa. DO NO	work dona du T use retired)	iring most of wo	orking					
21 The plant	Remembery/secondary (0-12)	College (1-401 5+)	Mana	aer			Lumbe	r Company			
	47 Eather's Name /First Middle I ass	Para - State of the state of			18. Mothar's Ne	erne (First, Middla,					
Maryland 22 should be file b and Mental Hy its marked othe traumetic event					Katheri	ne Passi	no				
San P	19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	ass (Street er	nd Number or F	Rural Routa Numbe	r, City or Town, S	itete, Zip Coda)	1		
M Sand	George R. Reiner/							, MD 21776			
- F A C T	20a. Method of Disposition		Place of Disposition (Nama of		Data		City or Town, Stete			
altimore mit. Pages 1 pariment of He cortant: if item r Injury or oth	Burial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		cematary, cramatory eadow Ridg			12/16/00	Elkridg	e, Marylan	ıð		
Baltim permit. Pa Departmen important: any lejury ancs.	21. Signature of Eunaral Sarvice Licer	Men	- 100	and Addrass S Fune	of Fecility ral Hom	10	illis St		7		
	23a. Part1. Entar tha disaasa, or com			Approximata Intarval Betw							
Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.										
/Medical	Immediata Cause (Final	5-1	.0								
Examiner	disease or condition rasulting in deeth)										
	Due to (or es a consequence of):										
		0.	D.								
68760, rifficate be asscuted 9 physician and as the bunal-transit	Sequantially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequenca of):										
Box 68760 death certificate be a entrending physician of for use as the buring for use a											
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G for d for	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	na causa giver	n in Part I.	23b. Did t	23b. Did tobacco use contribute to the cause of death?				
P.O. BOX at the death ce d by the attendi etached for use				,				3 Probably 4 ₩U			
							20110				
ord requir seen s hould						24a. Was a perfor	an autopsy med?	24b. Were eutopsy fir availebla prior to complation of ca)		
Receive See See See See See See See See See S							-/	of death?			
_ F # a						1 U Y	as 207No	1 Yas 2 P	No		
f Vital ysician: Th s certificate director, par	examinar?	Managhali				eeth (Check only o	ne)				
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Attending or death. Actor: After by the fune	2 ☐ Accident investigation		М	1 O Y	as 2 No						
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Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After compistely filled in by the funeral Maddical Cartillocal Car		ysicien: To the best of my kn niner: On tha basis of axamin and mannar stated.									
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F3F8	L. V								2000		
	Cysu of	~ M.D.		D 5	41	/	PCCOM	rroll Courter, MOZ	2000.		
	30. Nama and addrass of person who	M.D	atca	rroll Con	nty						
	General Hosp	IN at	200 mer	miap	Hveni	re, W.	estmins	ter, MOZ	1157		
State	nend da	32. Ragistrer's Sign	neture	1							
Registrar	11-1 1 2	MILLION DESCRIPTION		10- 1	1 1						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 42354

			Ce	ertificat	e of	Death		Re	g. No.			
	1. Decedent'a Name (First, Middle, La	est)	77	42				2. Dete of Death Month	Dey	Үөөг	3. Time of Deat	h
Physician /Medical	William	Noble I	Brown,	Jr.				December	23, 2	2000	9:30 p.1	m.
Examiner	4a Fecility Name (If not institution, gh 21305 Three Notc					4b. City, To Lexing		eation of Death Park	4c. County	of Death	ry's	
Funeral Director		Sex 7. Age (In yrs 1	. last birthday Yrs.	Months	1 Year Deys	If Under Hours		8. Date of Birth (Month, Dey, Oct. 13,		9. Birthp Cour Wash:	elece (State or Fondatry) Lngton, D.	eign . C .
the Maryland 26a-f show politied.at ector	10a. Stete 10b. County 10c. City, Town or Location Maryland St. Mary's Lexington Park									1	0d. Inside City Lin	
Dir Dec	10e. Street end Number 21305 Three Notch			10f. Zip				10g. Citizen of Whet Country? United States				
her dea her dea her ma flant ma	11. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No 19 If Yes, Giva		13. Was Decedent of Hispanic Origin? (Specify Y It Yes, specify Cuban, Mexicen, Puerto Rican, 1 ☐ Yes 2 ♣ No Specify:					14. Rac Bled		etc.	
21215-0 ed within 72 ho ser than "rature it, the Medical Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usua re kind of wo DO NOT us	rk done	during mos	t of workin	1	6b. Kind of B	usiness/Inc	dustry	
	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last	College (1-4or 5+)		Elect	rici		ar's Nama	(First, Middle, M	.S. Go		nent	
ylanc wild be to whethal H whethal H office ever To Be	William Noble Bro							ene Mick				
Mary d 2 sho	19e. Intormant's Neme/Reletionship							Routa Number,				
altimore, mit. Pages 1 ar partment of Hea portant: if Hean; y Injury or other	20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremefory or other place) Maryland Veterans Cemetery 1/2/200 Cheltenham 21. Signature of Fundament Fundament Survey (Specify)									City or To	own, State	nd
W FORES	Mary B-Rizze	MD1114	B	rinsf	ield ox 2	75 une	ral H eonar	Home, P.	Maryla	nd 20	0650	
Physician /Medical Examiner	23e. Part 1. Erfer the disease or book of hant lature. Lin construction of the constru	a. Respir	ato,	equence ot):	Fa,	lure	2_		st,	1	Approximate Intervet Batween Onset end Death	1
Box 68760, eth certificate be executed the certificate be executed for use as the burial-trensit claryMedical Examiner	Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Dista	(or as e conse	equence ot):	f 1	fasi	S	9				
	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Failure to Thrive								23b. Did tobacco use contribute to the cause of death'			
								24a. Wes an		av	ara eutopsy tindin allable prior to implation of ceuse daeth?	-
Vital Re- ician: The lev certificate hes rector, page 2 Be Comp								1 ☐ Ye	s No	1 (☐Yes 2☐No	
Of Vita Physician: this certific ral director.	25. Was cese reterred to medical examiner?	Hospitat:			Ot	har		(Check only one				
On of aling Phys h. After this funeral di	1 Yes 2 No 27. Menner of Death 1 Naturat 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey Year)	28b. Time Injury	ot a	28c. Inju Wo	4 🗆 14	No 2	28d. Dascribe hor	w injury occur	red	fy) al Route Number,	
Division to the Hospital or Attendinin 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	4 Homicide determined	building, etc. (Spec	ify)			ima, data en		City or Town,	, Stete)			
To the Hospital Within 24 hours To the Funeral Completely filled Medical C	(Check only 2 Medical Examone)	miner: On the basis of examin and manner steted.	ation and/or i	invastigation	, in my	opinion, das	th occurre	ed at the time, da	te end place,	and dua t	o the cause(s)	1
1 × 1 × 2	29b. Signeture and title of certifier Ry H. 13 w	nake, m. t	>.			se number 2189	73		d. Date signe			
dog	V								Lexi	ngtr	n Pk, M	2
State Registrar	31. Date filed (Month, Day, Year) DEC 2.8.2	completed cause of death (Ite NAUES, M.) 32. Registrar's Sign	nature	1	000	de					12060	0



epartment	01 1	realth and	mental	ну
0-416-4	-6	Donath		

-			Certificate	of Death	Re	g. No.				
nysician	1. Decedent's Neme (First, Middle, L.	ast)	2. Dete of Deeth Month Day DECEMBER 17, 2000 2:30PM							
Medical	Katie	Mungo	Bland			R 17, 2	2000 2:	30PM		
caminer	4a Facility Neme (If not institution, go	ve street end number)		4b. City, Town, or	Location of Death	4c. County of	of Deeth			
	St. Mary's Hospit	:al		Leonard			Mary's			
eral	5. Sociel Security Number 6.	Sex 7. Age (In yrs.	i Months l	Veer If Under 24 Hrs Days Hours Min.	8. Date of Birth (Month, Day. December	Year)	9. Birthplaca (St Country)	lete or Foreign		
ctor	217-32-2622	88	Yrs.		December	25, 19	llCaroli	ina		
	Usual Residence of Decedent	40-04					40d Inst	de Olhe Limite		
Man 70	10a. State 10b. County	10c. Cit	y, Town or Location					de City Limits		
cto illes	Maryland St. M	lary's	Lexington Pa	ark			'''	Yes 2⊠No		
Directo	10e. Street and Number		10f. Zip	Code	10	g. Citizen of W	hat Country?			
	21613 Liberty S	Street		20653		U	S A			
Funeral	11. Maritel Stetus	12. Was Decedent Ever in U	S. 13. Was Deced	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer	Specify Yes or No-		- American Indie	en,		
2	1 Never Married 2 Merried	Armed Forces? 1 ☐ Yes 2 ☒ No			to Hicari, etc.)		c, White, etc.			
p	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:		Specify:	Black	K		
	15. Decedent's 8	Education	16a. Decedent's Usua	Occupation	1	6b. Kind of Bus	siness/industry	10-1-		
ole	(Specify only highest g	rede completed)	(Give kind of work	done during most of wo retired)	orking					
Completed	Elementary/Secondary (0-12) 7th grade	College (1-4or 5+)	Homemake			Own	Home			
	17. Father's Neme (First, Middle, Las	(I)	1.0mcmare		me (First, Middle, M					
Be		Mungo		Lula		Pat				
5			40h Mailine Adda		humi Davia Mumb					
	19e. Informant's Name/Relationship Iris Bland (Day	(Type, Print) ughter)		(Street and Number or R rty Street,				nd2065		
	, ,	0								
	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3	DRamaval from States	Pleca of Disposition (Nem cametery, cremetory or of	her pleca)			City or Town, Sta			
	4 Donation 5 Other (Spec		rles Memori	al Gardens	12/21/2000) Leona	rdtown,	Maryla		
Ē 48	21. Signature of Juneral Service Lice	2000	22. Name end	Address of Fecility ield Funera	1 77 - D					
900	Zallann.	Su /					1 2005			
		sfield Jr.MOO		ox 279, Leo						
	23e. Pert1. Enter the diseese, or con shock, or heert failure. List onl	mplications that caused the deet y one cause on each line.	n. Do not enter the mode	or dying, such es cardia	to or respiratory erre	3 1,	Interva	ximete al Between and Death		
ian		10								
al er	Immediate Cause (Final disease or condition	· ATheron	rlaste	e (Arede	o Vserl	th d	neme d	145.		
100	resulting in death)		or as a consequence of):					1		
Examiner										
am	Sequentially list conditions.	Due to (d	or es e consequence of):			1-1-1				
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury						1			
edical Examin	that initiated events	C. Due to (o	r as e consequence of):							
8	resulting in death) Lest	250 10 (0	and an analysis of the							
3	Andrew Control	l d								
200					1 251 511		4.10. 41.6.11			
Physician/N	Pert II. Other eignificant conditione			ause given in Pert I.			tribute to the ca			
	Ren	& FAILURE			1 🗆 Ye	e 2□ No	3 Probably	4 Unknow		
by	100	1 100000	Charles - Colores							
Completed					24e. Wes er perform		24b. Were euto available	prior to		
olet							completio of death?	n of cause		
E					1 □ Ye	s 2 No	1 ☐ Yes	20 No		
	OF Manager to the second						10 105	7.10		
Be	25. Was case referred to medical examiner?	Hospitel: 1		Othor	eth (Check only one					
To	1 Yes 2 No	1 A Inpatient 2	ER/Outpatient 3 DO	A 4 Nursing	Home 5 ☐ Reside					
	27. Manner of Death 1 Polynerial 5 Pending	28a. Dete of Injury (Month, Dey Year)		Bc. Injury st Work?	28d. Describe ho	w injury occurr	ed			
cation	2 Accident investigati		М	1 ☐ Yes 2 ☐ No						
If o	3 Suicide 6 Could not determine	be 28e. Placa of Injury - At h building, etc. (Specif	ome, farm, street, factory	, offica	28f. Location (Str City or Town	reet and Numb , Stete)	er or Rurel Route	Number,		
Certification:		ounding, and Jopech	"		-					
	29a. Certifier 1 Certifying F	Phyeician: To the best of my kno	wiedge, deeth occurred	at the time, date and place	ce, end due to the ce	use(s) and ma	nner as stated.	10		
edicai	(Check only one) Medical Exp	miner: On the basis of examina and manner steted.	tion and/or investigation,	in my opinion, death occ	curred at the time, da	ite and placa, a	and due to the ca	iuse(s)		
0	Urie)									
Medical Certifi	29b. Signature and title of certifier	/	290	. License number	25	d. Date signed	(Month, Day, Y	ear)		

State Registrar

31. Date filed (Month, Day, Year) DEC 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. WILLIAM BOYD II LEONARDTOWN, MD.

DHMH 16 Rev 6/95

BLAND

NAME: KATIE

D14285

20650

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 21 **Physician** 2000 10:30 AM Merle S. Blair /Medical 4a Facility Nama (If not institution, give street and number)
Chesapeake Future Care 4b. City, Town, or Location of Death 4c. County of Death Examiner Anné Arundel Arnold If Under 1 Year | If Undar 24 Hrs. 8. Dele of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 10 M 20 F Hours Director 578 12 5649 84 May 20, 1916 RI Usual Residence of Decedent the Maryland 10a State 10c City Town or Location 10h County 10d Inside City Limits must be notified at MD Anne Arundel Arnold 1 Tyas 2 No Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 305 College Parkway 21012 IISA death Funeral al Hygiene. I other than "natural", or fleme 2? event, the Medical Example must 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black, Whita, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify: by 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) proprietor utility construction 18. Mother's Name (First, Middle, Maiden Surnema) 17. Fathar's Nama (First, Middla, Lest) Pages 1 and 2 should be file ment of Health and Mental Hy ant: if Nem 27 is marked oth lury or other traumatic event Merle Smith Blair, Sr. Batchelder Marquerite 19b. Meiling Address (Straat end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Ann Turner (daug.) 5956 Solomons Island Rd., Tracy's Landing, MD 20779 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from Stete St. James Parish Cem. 12-23-00 Lothian, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Rausch Funeral Home, Owings, MD 23a. Part1. Enfer the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. Approximate tnterval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in deeth) /Medical weeks Chebrovascular Examiner Examiner ears physician and s the burial-trens Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Records, P.O. Box 68760. the death certificate be Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequanca of): 88 attending p 23b. Did tobacco use contribute to the cause of death? signed by the a Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown insutt þ 24b. Were eutopsy tindings available prior to 24e. Wes an autopsy performed? Completed completion of cause of death? irector, page 2 s 1 sertension 1 Yas 1 Tyes 2 No Division of Vital 25. Was cese referred to medical exeminer? Physician: Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes ≥ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Naturel
2 Accident or Attending 5 Pending invastigation 1 ☐ Yes 2 ☐ No death. Director: / 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours at Funeral D letely filled i Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

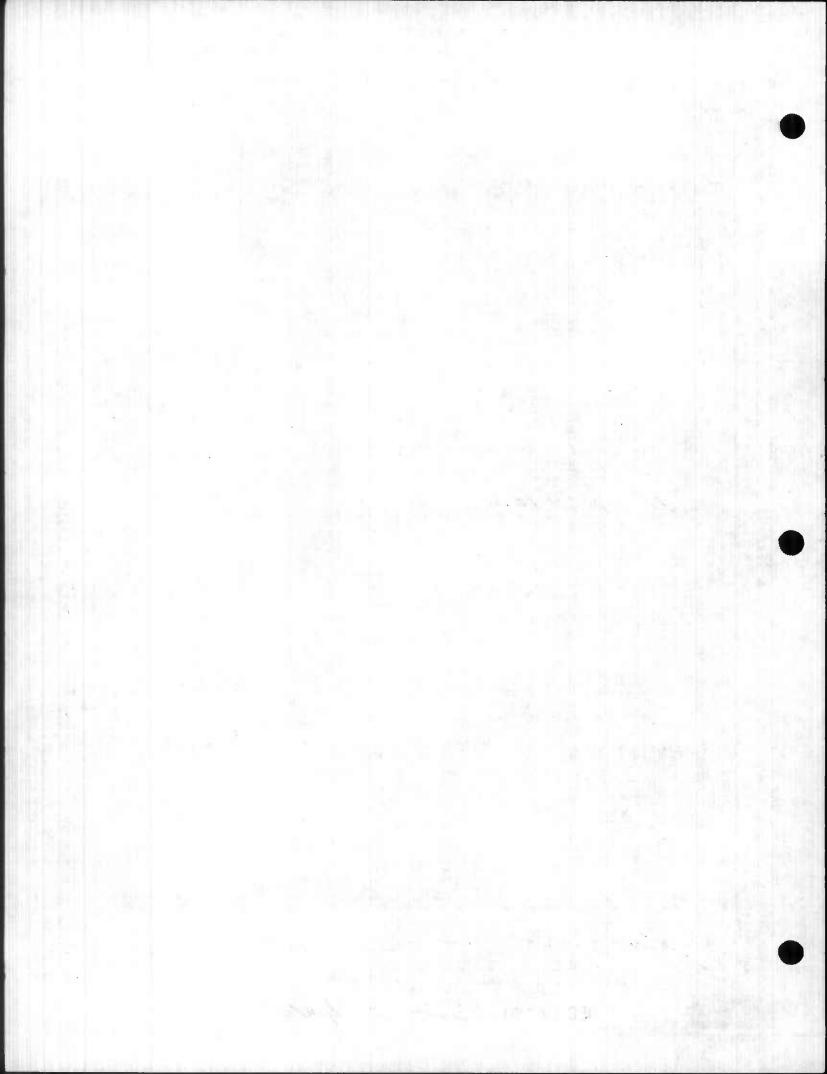
Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) within 2 To the 29c. License number 29d. Dete signed (Month, Dey, Year) 12-21-00 #304 Severna Parke MD 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 479 Jumpers Holo Rd

State

Elon

32. Registrar's Signatur Sene

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 42357

			C	ertificate d	of Death		Reg. No.					
	1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth									eath		
Physician	Joseph Adams B	arber				Month Decemb	per 12,	2000	8:17 7	AM		
/Medical Examiner	4e Facility Neme (If not institution, gire				4b. City, Town, o	Location of Deeth						
varriirie:	37650 Lockes Crossing Road Mechanicsville St. 1											
al	5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthda	y) If Under 1 Ye			th Vone	9. Birthpl	lace (Stete or Fi	oreigi		
or	215-14-6766 Usuel Residence of Decedent	1 X M 2□ F	78 Yrs.	Months De	ys Hours Mir		20, 1921		yland			
	10a. Stete 10b. County		10c. City, Town or	Location				10	0d. inside City I	Limits		
ŏ	Maryland St. Mar	771c	Mechan	icsville					1 Yes 2	No No		
Director	10e. Street end Number	-y 3	Pascriari.	10f. Zip Cod	9		10g. Citizen of V	What Coun	itry?			
	37650 Lockes Cros	ssing Road			659		U.S.A.		.,,.			
era	11. Meritel Status	12. Wes Decedent	Ever in U,S. 1:	3. Was Decedent	of Hispenic Origin? (Specify Yes or No		e - America		-		
by Funeral	1 ☐ Never Merried 2 🕅 Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 1 If Yes, Give Yeer or Detes:	40	If Yes, specify C	Cuben, Mexicen, Pue No Specify:	rto Rican, etc.)	Specify	ok, White, e				
Completed	15. Decedent's E	ducetion	16e. De	cedent's Usual Oc	cupetion	4.	16b. Kind of Bu	usiness/Ind	Justry			
ple	(Specify only highest gr Elementery/Secondery (0-12)	ode completed) Cotlege (1-4or :	(Gi	ve kind of work do b. DO NOT use re	ne during most of w tired)	orking						
E	12th	Counge (1-40)		ansport !	Driver		Oil Com	pany				
Be C	17. Father's Neme (First, Middle, Last)	ATT TO STATE OF		. ,	ame (First, Middle,	Maiden Sumen	10)				
0	Ninian Pinkney	Barber, S	r.		Pauli	ne Adams						
-	19e. Informant's Neme/Retetionship			eiling Address (Str	eet end Number or F	Rural Route Numb	er, City or Town,	State, Zip	Code) 200	659		
	Mary Lou Barber (Spouse)			s Crossin				200			
	20e. Method of Disposition	P	20b. Plece of Dis	position (Neme of		Dete	20c. Location -					
	1 Burial 2 □ Cremation 3 □			remetory or other					M			
	4 ☐ Donetion 5 ☐ Other (Speci		Charles		l Gardens	12/15/00	Leonaro	itown,	, Mary 18	ano		
	22. Signetyre of Funeral Service Licensee 22. Neme end Address of Fecility Mattingley-Gardiner Funeral Home, P.A.											
CI .	Muchael 111	4 Xandy	u t		x 270, Le							
	23a. Part1. Enter the diseese, or con shock, or heart feilure. List only	plications that caused	the death. Do not	enter the mode of	dying, such es cardi	ac or respiretory e	rrest,		Approximete Intervel Between	on		
an I	shock, or heart fellure. Lyst only	one ceuse on eech ii	10.					1	Onset end Dec			
al I	Immediate Cause (Final											
r	disease or condition resulting in deeth)									monufa		
5			Due to (or es e cons					1	. 14			
Examiner		b. aggres	sme we		prostole	centor		in	novigus			
X	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Undertrying Cause (Disease or injury c.											
	Cause (Diseese or injury	c						1				
edical	thet initieted events resulting in deeth) Last		Due to (or es e cons	sequence of):				1				
100	22477	d										
lan								1				
Physician/	Pert II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause	given in Pert I.	23b. Did	tobacco use co	ntribute to	the causs of	death?		
Phy	Communa . A.	na det				10	Yss 2□ No	3 ☐ Prot	bably 4 Tun	know		
by	- or over I or to	T wear										
8	chronic of	11.045	And I was a fe	August			en eutopsy	24b. We	ere eutopsy find ailebte prior to	dings		
o et	masma ex	stroum	hologing	arsewse			,,,,,,		mptetion of cau deeth?	se		
Completed						10	Yes 2 (No	10	Yes 2□ No	0		
Ö	25. Wes cese referred to medicet				OC Diseased D			1				
00	examiner?	Hospitel:			Other:	eeth (Check only			L.)			
10	1 Yes 2 No	1 linpatie			4 Li Nursing	Home 5 AResi	dence 6 LIOth how injury occur		<i>y</i>)			
Certification:	1 Neturel 5 Pending	28e. Date of Inju (Month, De	y Year) 280. Time	у	njury et Work? 1 □ Yes 2 □ No	203. 0030108	injury occur	. 54				
cat	2 Accident investigation 3 Suicide 6 Could not t		ANI			206 1 00000	Ctroot and the	har or O	I Dougla Alicant	0.0		
=	4 Homicide determined	286. Piece of in	ury - At home, farm, c. (Specify)	street, fectory, off	ice	City or To	Street end Numl wn, State)	per or Hure	Houre Numbe	Ir,		
	29a. Certifier 1 € CertifyIng Pl	nysician: To the best	of <i>m</i> y knowledge, de	eth occurred et th	e time, dete end ple	ce, end due to the	ceuse(s) end me	enner es s'	tated.			
Medical		miner: On the basis o end manner st	examination and/or									
×	29b. Signeture end title of certifier 29c. License number 29d. Date signed								Day, Year)			
	1 xon	M	THE REAL PROPERTY.	Dy	2597	2.40	12-17	1313				
	1010		- m		, 2 - 1 -		. 7-16					
	30. Neme end eddress of person who											
	Jeffrey Brown,	MD Leon	ardtown,	Maryland	20650							
State	31. De Green Manti Day, Year)	32. Registr	er's Signeture	D								

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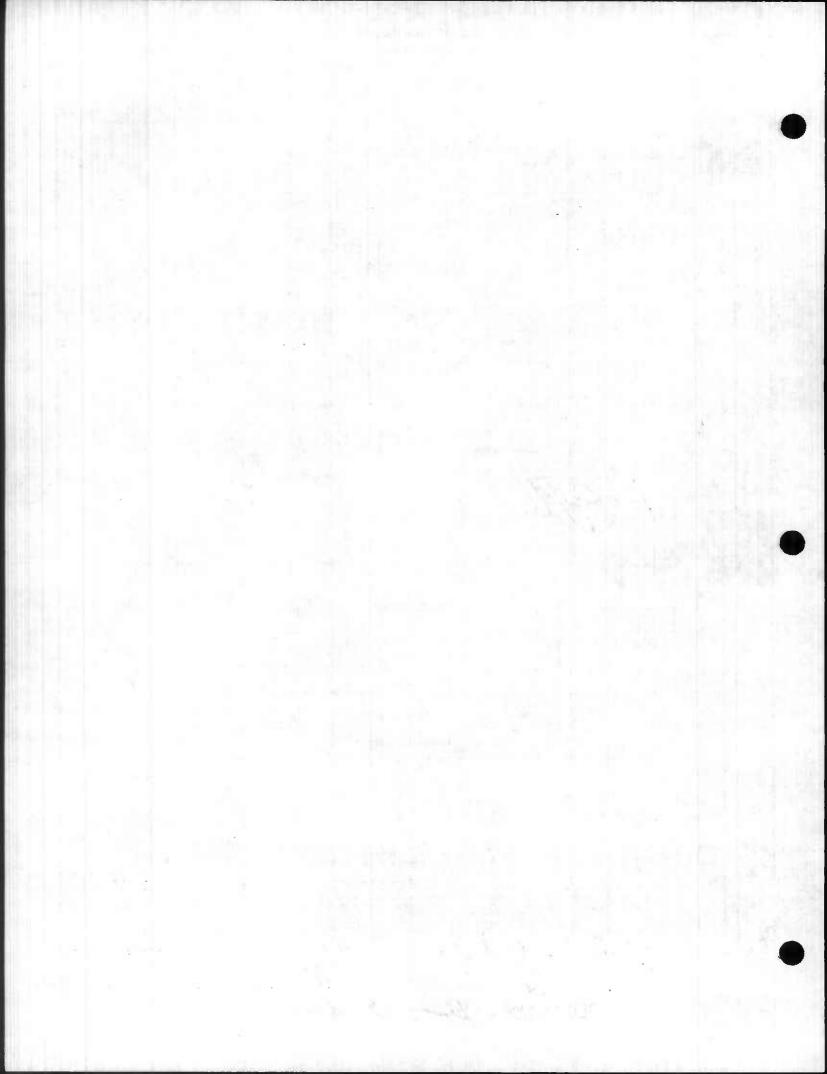
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State of Maryland / Department of Health and Mental Hygiene

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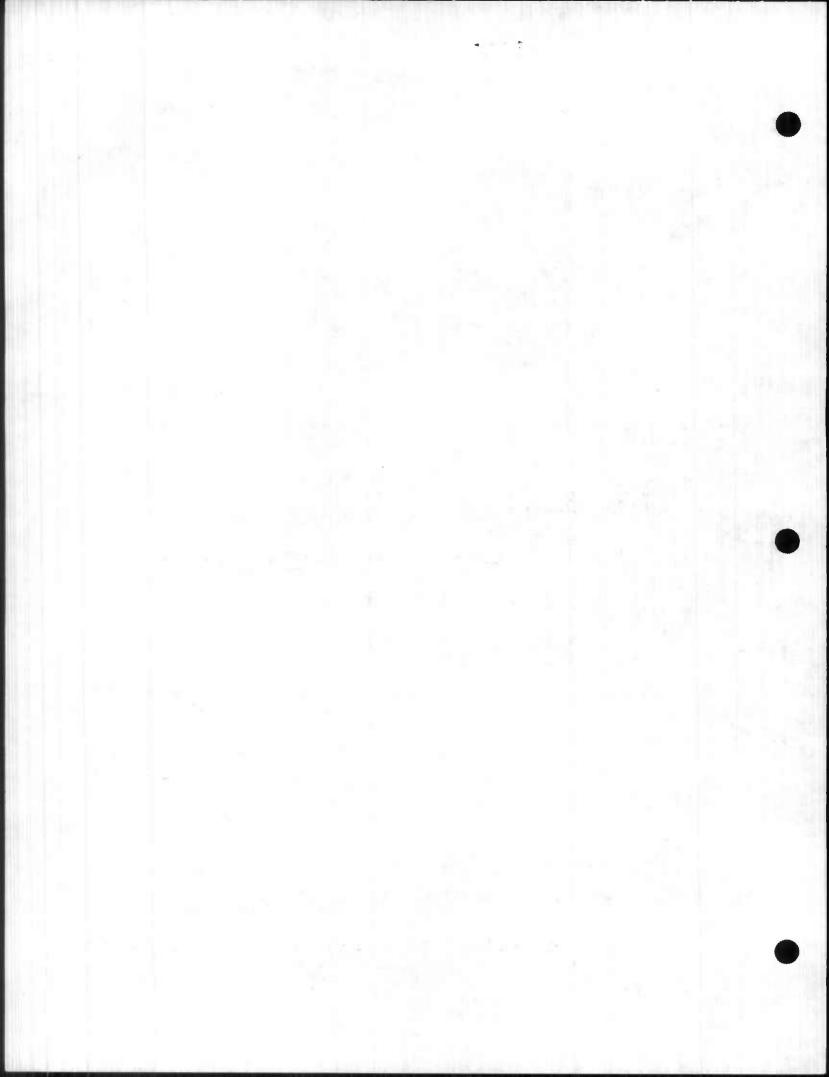
ASP		Certificate of Death		Reg. No.	42358					
		1. Decedent's Nama <i>(First, Middla, Last)</i> James Dorsey Baki	2. Data of Month DECEN	Death Day	3. Tima of Death Yaar 2000 2345					
		4a Facility Nama (If not institution, giva street and number) 4b. City, To PRINCE GEORGES HOSPITAL CHEV.	own, or Location of De	eath 4c. County PRIN	y of Death					
Funeral Director		5. Social Security Number 2 1 7 - 4 4 - 9 1 4 0 6. Sety 2 F 7. Aga (In yrs. last birthday) 1 Under 1 Year If Under 2 1 7 - 4 4 - 9 1 4 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Min. (Month,	Birth Day, Year) 2 8, 1947	Birthplaca (Stata or Foreign Country) Mary Land					
Maryland of show fled at	tor	Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location Lusby 10b. County 10c. City, Town or Location 10c. City, Town			10d. Inside City Limits 1 ☐ Yas 2 → No					
h with the 25s or 28s at be not		10e. Street and Number 13525 Olivet Road 10f. Zip Coda 20657		10g. Citizen of Unite	What Country? ed States					
036 vurs after deat alf., or items	by	11. Marital Status 1 Nevar Marriad 2 Married 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar in U,S. Armed Forcas? 1 Nevar Marriad 2 Married 1 Nevar Marriad 3 Mas Decedent of Hispanic Ori If Yas, specify Cuban, Maxical Marriad Status 1 Nevar Marriad 3 Mas Decedent of Hispanic Ori If Yas, specify Cuban, Maxical Marriad Status 1 Nevar Marriad 3 Married 2 Married Marriad 3 Marriad Forcas? 1 Nevar Marriad 3 Married 3 Married Marriad 4 Marriad 5 Marriad 6 Marriad 6 Marriad 6 Marriad 7		No- 14. Rac Bla Specif	ce - Amarican Indian, ck, Whita, atc. by: White					
21215-0036 d within 72 hours at giens, "natural", or the Medical Exem	Physician: The lew requires that the deeth certificate be executed by the attending physician and important; If then 27 is marked other than 12 hours after than 22 should be deteched for use as the burial-transit are in a part of the completed by Physician Medical Examiner. To Be Completed by Physician/Medical Examiner. To Be Completed by Physician/Medical Examiner.	15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedant's Usual Occupation (Giva kind of work dona during mos life. DO NOT use retired) Master Plumber	st of working		dusiness/Industry					
land and and and and and and and and and	Be	17. Fathar's Nama (First, Middla, Lest) Louis Baki 18. Mother	ar's Nama (First, Mid Nellie	die, Maiden Sumar OSDOTT	na) 1 e					
Mar and 2 sho aith and 127 is me or traum		Nellie Osborne Baki-Mother 19a. Informant's Name/Relationship (Type, Print), Nellie Osborne Baki-Mother 13525 Olivet R								
Pages 1.		20a. Method of Disposition 1 Maurial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of compatany, cramatory or other place) Olivet Church Cem.	Dec. 26,		- City or Town, Stata usby, MD					
Balt pemit Department imports any inje		21. Signature of Funeral Service Licensee MO1095 22. Nama and Address of Facility 4405 Broomes	Rausch	Funeral	l Home 20676 Republic, MD					
/Medical	er	23a. Port Enter the decision of complications that caused the death. Do not anter the mode of dying, such as such as or hear failure. It st only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	s cardiac or raspirator	y arrast,	Approximata Intarvat Batween Onset and Death					
2 0 8	edical	Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disease or injury that initiated avents rasulting in death) Last b. Dua to (or as a consequence of): c. Dua to (or as a consequence of):			t 					
yeldan: The law requires that the deeth certificate be executed to see a signed by the attending physician and director, page 2 should be deteched for use as the bunk-transit.	hysiciar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		23b. Did tobacco use contribute to the cause of death?						
requires that	by									
al Rec			1	Yas 2□No	of death?					
f Vit yaiclan is certif directo	ro Be	axaminar? Hospital: Other:	a of Death (Check or lursing Homa 5 - F		ther (Specify)					
Division of mior Attending Physical Sector: After this of in by the funeral division of the funeral di	27. Manner of Death 1 Naturat 27. Naturat 1 Naturat 28a. Data of Injury (Month/Day Year) 28b. Tima of Injury (Month/Day Year) 28b. Tima of Injury 28c. Injury at Work? 1 Year 29c. Naturat 28c. Injury at Work? 29c. Specify)	(No Tuck		ber of Rural Route Nymber,						
he Hospit in 24 hour he Funers pletely fills	edicai	29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data at 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, data and manner stated.								
Of Figure 8	N	29c. Licensa number O.C.M.E			ed (Month, Day, Year) ER 23,2000					
Sta	ate	30. Nama and addrass of person who complated causa of dwall (Item 23a) (Type, Print) 111 Penn St. 31. Data filed (Month, Day, Year) 22. Registrary Signatura	reet, Balt	imore, M	aryland 21201					

Registrar



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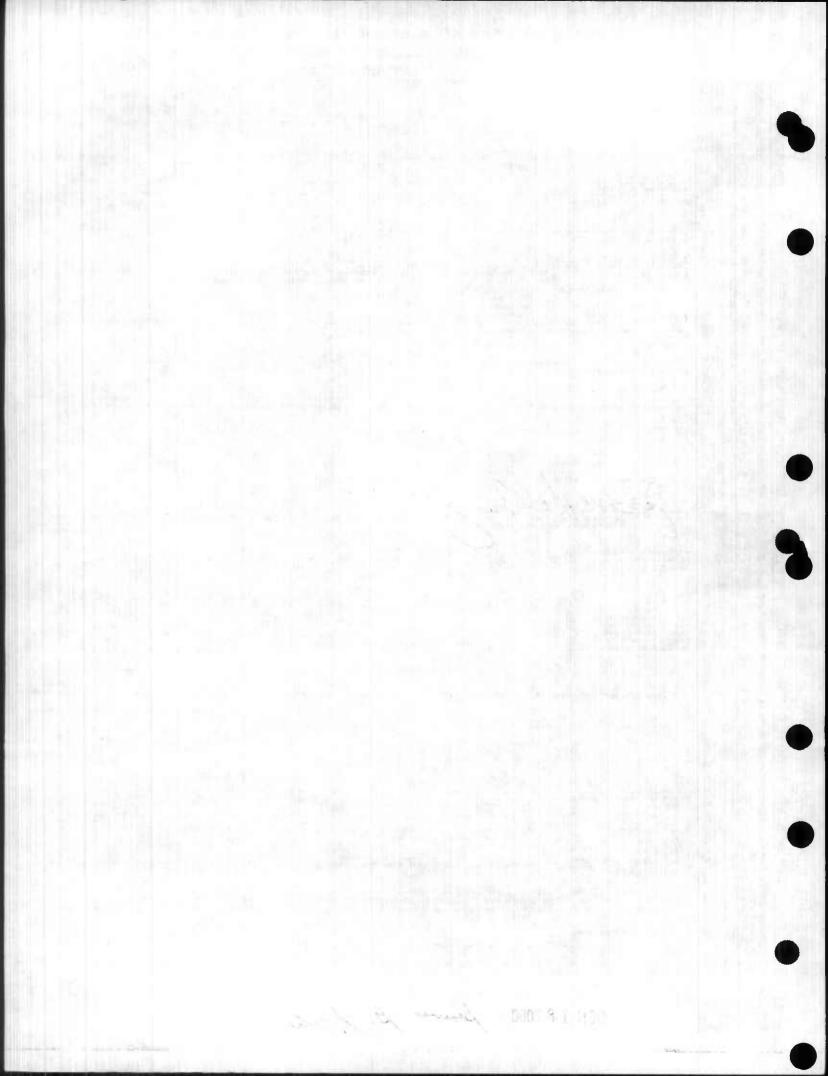
							Certifica	ate of	Death			Reg. No.			
10.00		1. Decedent's Nam	na (First, Middla, La	ist)							2. Data of Dea	ath Day	Yaar	3. Tima of Death	
Physi- /Med		Norwood	James Bal	ker. Sr								3/2000	1 001	10:30 AM	
Exam			(If not institution, given						4b. City, Town, or Location of Death 4c. County of Death						
		628 William Street Berli								n		Wo	rcest	er	
Funera	i	5. Social Security I	Number 6. S	Sex	7. Aga	(In yrs. last bir	thday) If Und Month	dar 1 Yaa	r If Undar	24 Hrs. Min.	8. Data of Birt (Month, Da	h		placa (Stata or Foraign	
Directo	r	216-10-3430 INTERPOLATION OF STATE OF S									4/24/19			yland	
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiens. T is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Medical Examinar must be notified at	ctor	10a. Stata MD	Worcest	er		10c. City, Tow Berli							1	10d. Insida City Limits Yas 2□ No	
or 28	Director	10e. Street and Nu	ımber				10f. 2	Zip Coda				10g. Citizen o	f What Cour	ntry?	
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Baltim permit. Pag Department Important: I		21. Signature of F	une al Service Lice	ulo0_			Burbag		neral		2	Villian in, MD	n Stre 218		
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. Box 68760, death certificate be axecuted e attanding physician end of or use as the bunal-transit	Medical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of):													
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To the To the comple	Mex	29b. Signature and	d title of certifiar	and mai	तावा अवि	od.		29c. Lica	nsa number			29d. Data sig	ned (Month	, Day, Year)	
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		State of Marylan	d / Departme Certifica			d Mental H	ygiene [] [Reg. No.) 4	2360		
	1. Decedent'a Name (First, Middle, Las	1)				2. Date of D	Death	V-1	3. Time of Death		
Physician	Ruth Val	lesca Bu	ck			Decem	ber 15 a	Year	0655		
/Medical xaminer	4a Facility Name (If not institution, give PENINSULA REGI		ENTER	4		or Location of Dec		of Death			
uneral	Social Security Number 6. S			er 1 Year	If Under 24		lirth	9. Birthple	ace (State or Foreig		
ector	579-34-4305	□M 2 ⊠ F 77	Yrs. Month:	s Days	Hours		/1923	Count	yland		
	Usual Residence of Decedent					, 0, 20,					
ral Director	10a. State 10b. County	10c. City	, Town or Location					10	d. Inside City Limits		
cto	MD Wicomico	S	alisbury						1 ☐ Yes 2 🖺 No		
Dire	10e. Street and Number		101. 2	Zip Code			10g. Citizen of	What Count	ry?		
8	31328 Johnson Road			2180				SA			
Funeral Director	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13. Was Dec	sedent of H secify Cuba	ispanic Origin In, Mexican, P	? (Specify Yes or huerto Rican, etc.)	lo- 14. Had Bla	ce - America ck, White, e			
by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No ff Yes, Give Year or Dates:	1 ☐ Yes	2 X) No	Specify:		Specify	y: whi	ite		
N N	15. Decedent's Ed		16a. Decedent's Us	ual Occup	etion		16b. Kind of B				
Completed	(Specify only highest grad	de completed)	(Give kind of v	vork done	during most of	working	100, 11,110 01 0		uotiy		
mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Social Wor				State	Gover	coment		
Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Midd	le, Maiden Suman	ne)			
0	Fulton W. Allen				Lois	V. Jenn	ings				
-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addre	ss (Street	and Number o	or Rural Route Nurr	ber, City or Town,	State, Zip	Code)		
	Leonard R. Buck	(husband)	31328 Jo	hnson	Road	Salisbu	ry, MD 2	1804			
	20a. Method of Disposition	20b. P	lace of Disposition (Nemetery, crematory of	lame of		Date	20c. Location		vn, State		
	1 □ Burlal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	ringhill M			12/19/0	Hebron	, MD			
	21. Signature of Fameral Service Licen		22. Name	and Addre	ss of Facility						
	10 mg 11	00//		-		Home, P		01.00			
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Medical Examiner	Cause (Disease or Injury that initiated evenis Due to (or as a consequence of):										
by Physician/Med	d										
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Completed b							as an autopsy rformed?	ava	ore autopsy findings hilable prior to inpletion of cause death?		
E						1[Yes 2 No		Yes 2□ No		
Be	25. Wes case referred to medicel				26. Place of	Death (Check on)					
To B	examiner?	Hospital: 1 Impatient 2	ER/Outpatient 3	DOA Oth	or.	ng Home 5 □ Re		her (Specify	<i>'</i>)		
l ä	27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of	28c. Injur	y at	28d. Describ	e how injury occu	rred			
atio	1 SNatural 5 Pending 2 Accident investigation		Injury M		Yes 2 □ No						
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al ho building, etc. (Specify	28f. Location City or 1	(Street and Num. Town, State)	ber or Rura	Route Number,					
Medical Certification: 1		/elclan: To the best of my kno iner: On the basis of examinal and manner stated.									
2	29b. Signature and title of certifier	, //)	2	29c. Licens	e number		29d. Date signs	ed (Month, I	Day, Year)		
	Ven A	MI	-	0-	257	19	17/	16/0	9 9		
	30. Name and address of person who o	completed cause of death (flow	23a) (Type Brint)		() /	ny md	1/1	0/1	1		
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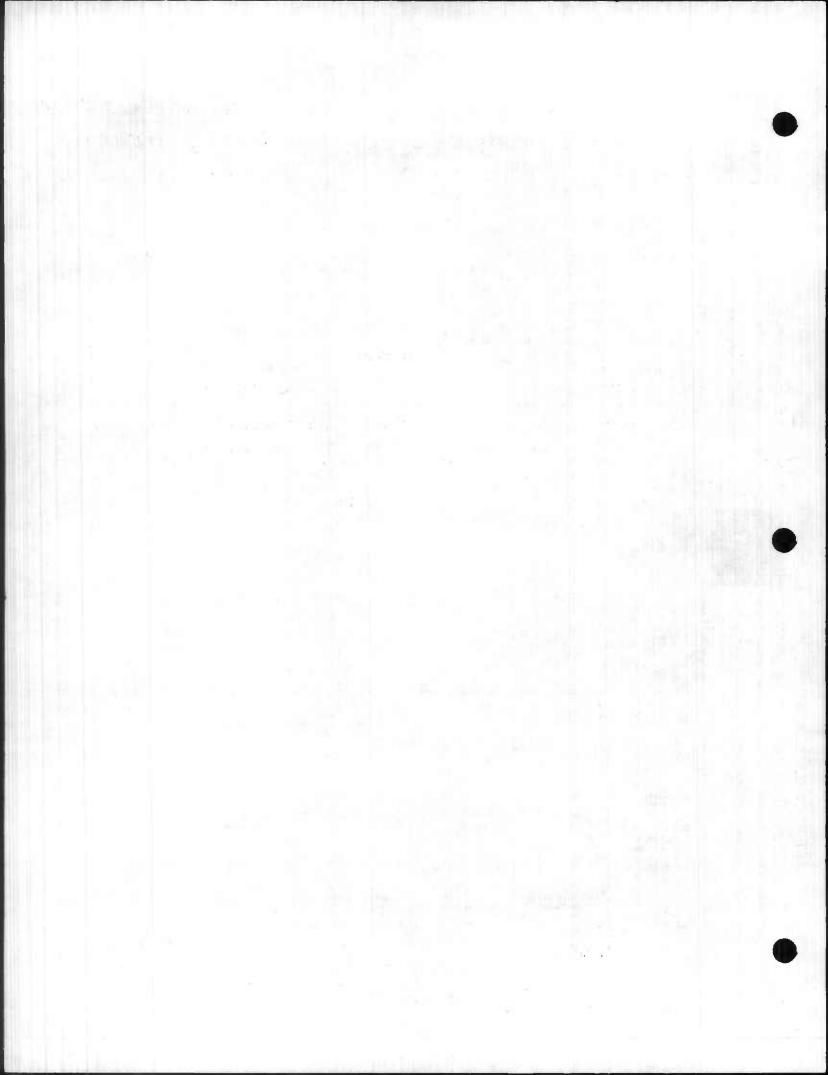
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death Dey Month. Year **Physician** c 19, 2000 4c. County of Death 8:30 AM Elsie Mitchell Bailey December /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Havre de Brace Citizens Nursina Home If IJnder 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs Director March 3, 1903 216-14-3327 Maryland Usual Residence of Decedent with the Maryland works ! 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show 1 ☐ Yes 2 No Director Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Brenda Street 21904 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status 72 hours after 1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Merried Baitimore, Marviand 21215-0020 1 ☐ Yes 2 No Specify: Specify þ 3 ₩ Widowed 4 Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit, Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumatic event, tra Man Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In her own home 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William T. Mitchell 2 Sarah Elizabeth Colgain 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 4th Avenue, Dorothy, New Jersey 08317 Doris Hemling / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removet from State December 22. 4 ☐ Donation 5 ☐ Other (Specify) 2000 Hopewell Cemetery Port Deposit, Maryland 21. Signature of Funeral Service Lipensee 22. Neme and Address of Facility Crouch Funeral Home, 127 South Main Street. North East, Maryland 21901 Approximete Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician ALCINOMA N METASTASTS /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? FOROSIS 1 Yes 2 No 3 Probably Unknown à ATIVE COCITIS 24b. Were autopsy findings evailable prior to eted 24a. Wes an eutopsy performed? completion of causa of death? Compl page 2 has 200 No certificate 1 ☐ Yas No Division of Vitai funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No death. Mospital or Attendi 24 hours after death. Funeral Director: A 6 Could not be To the Hospital or Atterview Within 24 hours after der To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title 29c. License number 29d. Data signed (Month, Dey, Year) who completed cause of death (Item 23a) (Type, Print) MO 3/95. Havre de Grace, Maryland 21078 State

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42362 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Frances Mildred Robb Buser 12:35 12 19 December 20 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HAVE de CRACE HOST HOME 5. Social Security Number Ursing TORD 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1□ M 2K) F Months Days Hours Min. 182-16-2212 88 Yrs. June 24,1912 Director Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. toside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at XXYes 2 No Maryland Cecil Directo Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 69 North Main Street 21904 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 200No If Yes, Give Year or Datas: 11 Manital Status Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: p White 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Buser Custom Upholstery parmit, Pages 1 and 2 should be filled within Department of Health end Mental Hygiene. Important: If item 27 ia marked other than ", College (1-4or 5+) Two Years Elementary/Secondary (0-12) Lancaster, Pennsylvania Interior Decorator & Owner/Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) Be Charles Robb Nellie Runkel 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carlene F. Poist (Daughter) 71 North Main Street, Port Deposit, Maryland other t 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 10 XX Burial 2 ☐ Cramation 3 ☐ Removal from State Conestoga Memorial Park 12/22/00 Lancaster, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) any Injury 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licenses Lee A. Patterson & Son Funeral Home, P.A. nonited M. Perryville, Maryland 21903-0766 JOHNELDON, J. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Daath **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Due to for as Examine iclan and burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Undarfying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physiclan a the burial Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown signed by 1 Yes 2 No þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? hes 2 000 1 ☐ Yes 2 No Be 25. Was case raferred to medical axaminar? 26. Place of Death (Check only ona) Hospitat: Other Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? Certification: 5 Pending investigation 1 Yes 2 No death. 2 ☐ Accident To the Hospital or Attend within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Cartifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29b. Signature and title of partition 29c. License number 29d. Date signed (Mgnth, Day, Year) 030

State Registrar

31. Date filed (Month, Day, Year)
DEC 22 2000

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death (Item 23a) (Type, Print)

32. Registrar's Signatura

Fig. Self. In Sedenburg Showing with a small

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Year An 4:30 15, 2000 December Burroughs Priscilla 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street and number) 4c. County of Death Clinton Southren Maryland Hospital Prince Georges If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Deys Min. Hours 1 M 2 TF 86 August 7,1914 Maryland 213-40-9796 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ¥ Yas 2 □ No Brandywine Maryland Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10a, Street and Numbe 14411 South Springfield Road U.S.A 20613 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Maritel Status Black, Whifa, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: Black 3₺ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middla, Last) R. Robert A. Neal Moore 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Hilda Bryant/Daughter 14415 South Springfield Rd Brandywine MD 20613 20b. Plece of Disposition (Neme of cametery, crematory or other pleca) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Asbury Un. Meth Ch. 12/20/00 Brandywine Md 21. Signature of Funeral Service Licensee 22. Name end Address of Facility M191 Adams Funeral Home P.A. Aquasco MD 20608 23a. Pert1. Engit the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart feilure. List only one cause on each lige. Approximate Intervel Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) Ulmo Normy Dua to (or es a consequence of): -ou une Sequentielly list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Grown Mac Jox Diseas Astonogolynotic Due to (or as e consequance of) resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown per de de pris 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examinar? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28d. Describe how injury occurred 28c. Injury et Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

200

72 hours after death

filled within 7 Hygiens.

should be f

permit. Pages 1 and 2 should be Department of Health and Mental I Important: If New 27 is merited on any Injury or other trauments

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

Directo

Funeral

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Completed

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Examiner Physician/Medical à

Completed

Be

Certification: To

edical

signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed cate has been signated by page 2 should b After this certificate has Physician: funeral director, ipital or Attending Prouss after death.

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

3 Suicide 4 | Homicide 29a. Cartifier

6 Could not be

Dete of Injury (Month, Day Year) 28b. Tima of

28e. Plece of Injury - At home, ferm, straet, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rurel Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier

29c. License number 0001923 29d. Date signed (Month, Day, Year) Bec 15, 2000

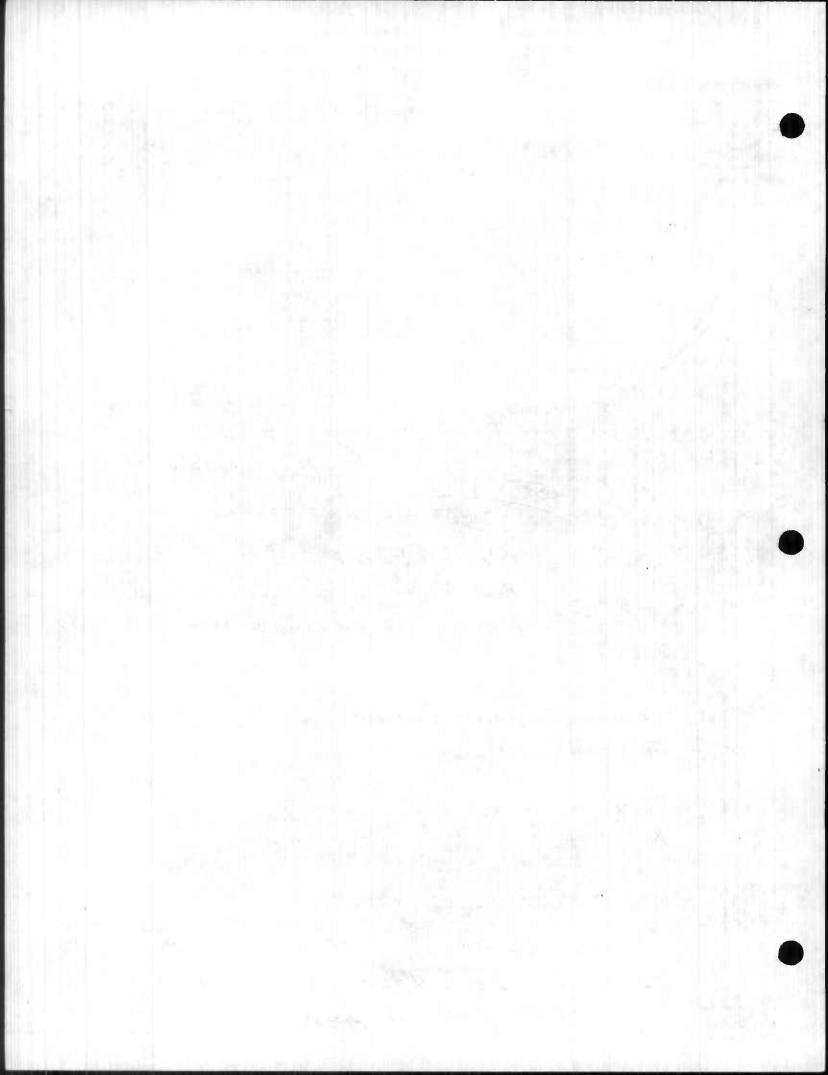
30. Name and eddress of person who completed causa of death (Item 23a) [Typ9, Print) Teld gon

31. Data filed (Month, Day, Year) DEC 26 2000

32. Registrer's Signature

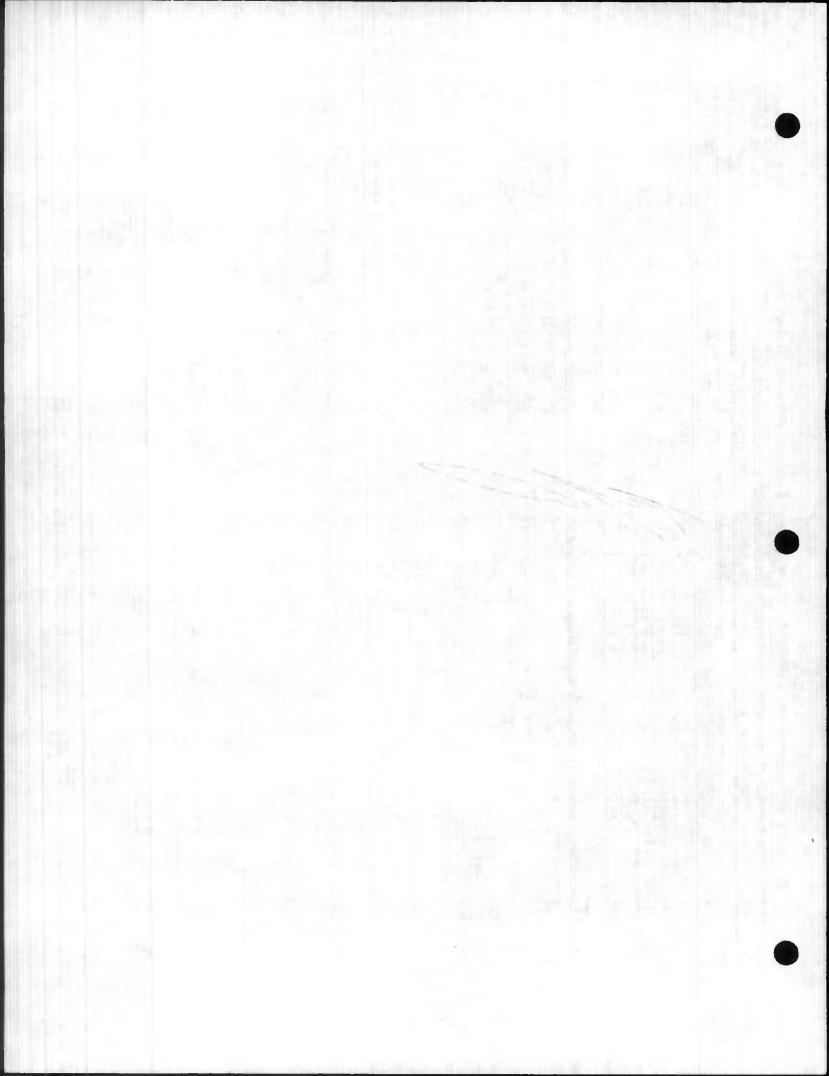
State Registrar

To the Hospital within 24 hours a To the Funeral C completely filled



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			Certificate of Death	R	eg. No.	
	141.		1. Decedent's Nama (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
	Physicia /Medic	_	Frederic Lorenz Bray	DECEM be		no 1300
	Examin	_	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death	4c. County of	Death
		-3	Union Hospital Elkton		Cec	il
	Funeral Director		056-10-5193 10 M 2□ F 93 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day)こた。14		B. Birthplace (State or Foreign Country) Colorado
П	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	or death with the Meryland Herns 23s or 28s-f ehow ner ment be notified at	Director	Maryland Cecil Elkton			1 ☐ Yes 2 No
	章 9 g	Dire	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wh	at Country?
	23a	ra I	9 East Parkway 21921		USA	
20	or he	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Yes 2 □ No 1 □ Yes 2 ☑ No	cify Yes or No- Rican, etc.)	Black, Specify:	American Indian, White, etc. White
5-0020	n 72 hours		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busi	
215	· · · · · ·	Completed	(Specify only highest grade completed) [Give kind of work done during most of working tife. DO NOT use retired) [Give kind of work done during most of working tife. DO NOT use retired]	ng		
217	illed within Hygiena.	E O	4 Motion Picture Engineer		Motion F	Pictures
	al Hygie other	Be C	17. Fathar's Nama (First, Middla, Last) 18. Mother's Name	(First, Middle,	Maiden Sumame)	
Maryland	s i end 2 should be filed wir f Health end Mental Hygien tem 27 is marked other thu other treumatic event, the	ToE	F.C.W. Bray Louise	Antoin	ette Meu	ther
any	end A		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural)			
Σ	alth e 27 is		Luise A. Williams/Daughter PO Box 912 Happy Co	amp, CA	96039	
re			20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place)	Date	20c. Location - C	ity or Town, State
Baltimore	permit. Pege Department o Important: If i any injury or once.		1 ☐ Burial 2 🕱 Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ☐ The State ☐ 22. Name and Addrass of Facility	2-26-00	west Ch	ester, PA
Ba	Depa Impo		R. T. Foard Funeral 111 S. Queen St., Re	Home,	P. A.	1011
	Physician /Medical Examiner	Jer	Impediate Cause (Final disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shoot that failure. List only one cause on each line. Impediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Interval Between Onset and Death
Box 68760,	certificate be axecuted nding physician and use as the burial-transit	n/Medicai Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.	n'llet	eg cm	6 months
ŭ	iras thet the death cer signed by the attendin d be detached for use	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h. Did to	obacco usa conti	ribute to the cause of death?
P.0	t the by the tache	hys		101	es 20 No	3 Probably 4 Unknown
	£ % D	by P	Coronary asterion Higene	-	,/	
Records,	v requ	Completed	(24a. Was a perfor		24b. Were autopsy findings available prior to completion of ceuse of death?
	siclen: The lav certificate hes irector, page 2	EO		1 🗆 Y	es 2 No	1 ☐ Yes 2 ☐ No
Vital	ysicien: The la is certificate he director, page	BeC	25. Was cese referred to medical 26. Place of Death	(Check only o	ne)	
\geq	Physicien: this certific ral director,	TOB	examiner?		ence 6 Other	(Specify)
of	g Phys ar this eral di	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	-	ow injury occurre	
Division	To the Hospital or Attending Phywithin 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident Investigation M 1 Yes 2 No	28f. Location (S City or Tow	itreet and Number	r or Rural Route Number,
Ö	rs aft	Cer	Containing, Gio. [Opposity]	- 1, 5, 1, 5,		
	e Hospi 24 hou e Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place, a construction of each occurred at the time, date and place at the construction of each occurred at the time, date and place at the construction of each occurred at the time, date and place at the construction of each occurred at the construction occurred at the construction of each occurred at the construction o	and due to the dead at the time, d	ause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
		Me	296. Signature and title of certifier 29c. Licensa number 29c. Licensa number 29c. 230		29d. Date signed 2 2	(Month, Day, Year)
	10 +1 VA		30 Name and address of person who completed cause of death (Item 22a) (Type, Print) 123 Singerly Hve, 2 (Kten MD 2)	921	_	
	Sta Registra		31. Date filed (Month, Day, Year) DEC 2 6 2000 32. Registrar's Signatura Apouls			



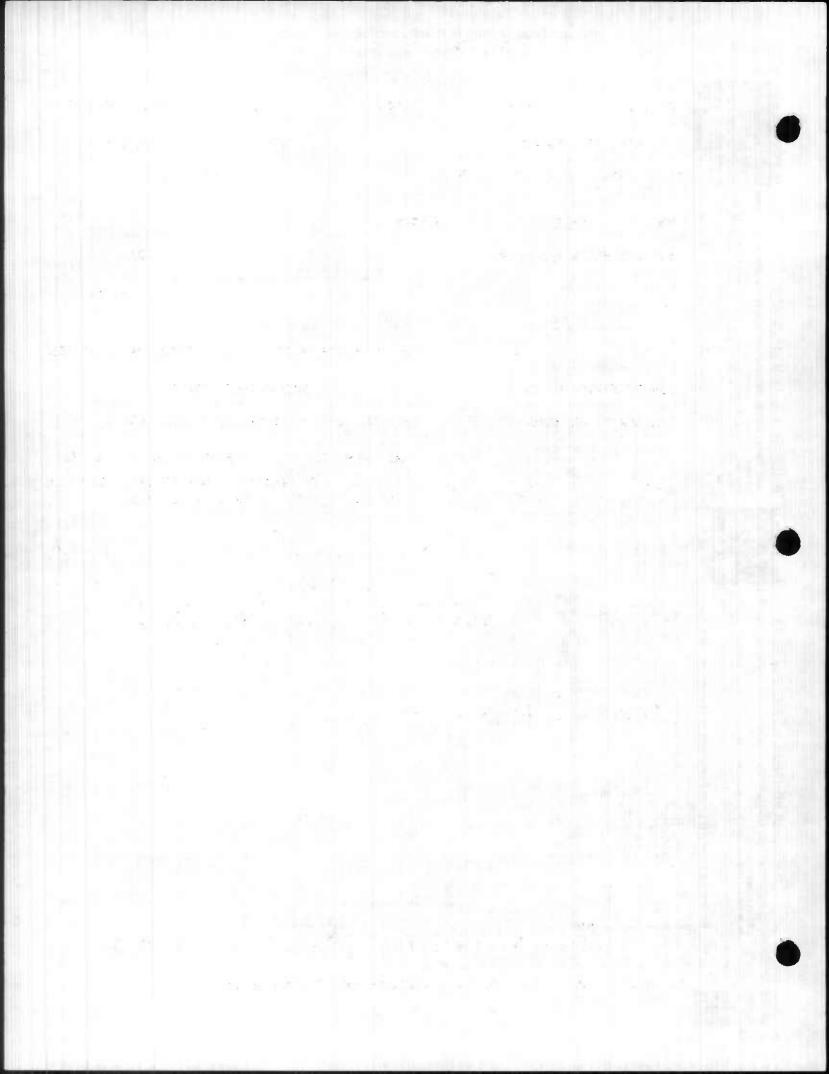
Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year December 16,2000 **Physician** Baker 8:10pm Margaret Woodward /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL MANOR EASTON TALBOT If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 200 F Months Days Yrs. Director 92 JAN 04 1908 MD 217-36-2055 Usual Residence of Decedent the Marylend 10c. City, Town or Location 10e State 10b County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at YOYes 2 No Director TALBOT MD EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 DUTCHMANS LANE RM#71 21601 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lt Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mentel Hygiene. Important: if item 27 Is marked other than "natural; or item any injury or other traumatic event, the Madical Example. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PUBLIC HEALTH NURSE STATE OF MD HEALTH 18. Mother's Name (First, Middle, Maiden Sumame) 17 Fether's Name (First Middle Last) Be JOSEPH NEWTON WHITE MARY EVELENE PRATT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BARBARA W. ANDREWS/DAUGHTER 48 DREW LANE, MIDDLEBURG, VERMONT 05753 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Mathod ot Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 12-18-00 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Ostrousk: Joseph S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Vegical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last bunel-tran pue physiclan Physician/Medical the 98 Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco usa contribute to the cause of death? signed by t detech 2 No 1 Yes 3 Probably 4 Unknown p 24b. Were autopsy tindings eveilable prior to completion of ceuse ot death? Completed 24a. Was an autopsy peen ; hes certificete 1 Yes 2 No 1 TYes 2 No. Division of Vital funeral director, Be 25. Was cese reterred to medical 26. Place of Death (Check only one) Other: 40 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 0 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this Certification: 27. Menner ot Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? After Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation or Attand efter death Director: 6 Could not be To the Hospital or Atta within 24 hours efter de To the Funeral Directo completely filled in by the 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature end title of Eaftitier 29c. License number 30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print)

State Registrar WILLIAM H. WOOD, JR. M.D. 505 DUTCHMANS LANE EASTON MD 21601 32, Registrar's Signature 2 merra

31. Date filed (Month, Day, Year) DEC 1 8 2000



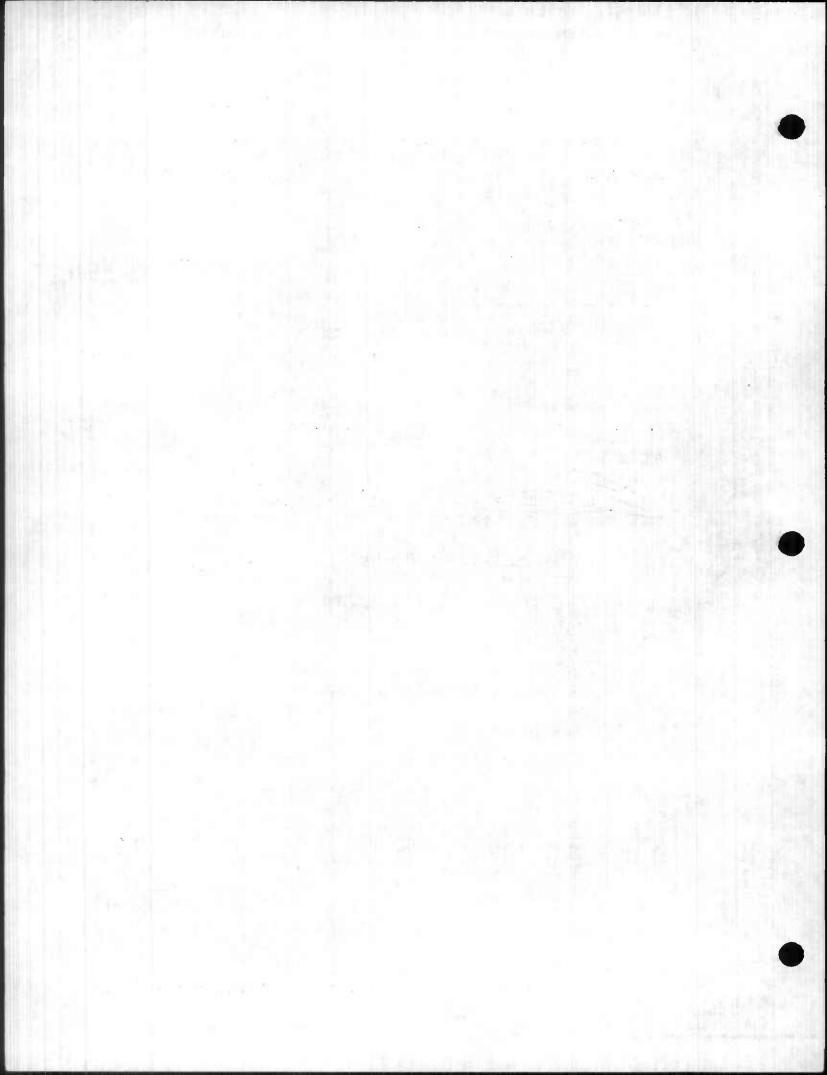
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be notified Directo	10e. Street and	Number		1011		10f. Zip (Code			10g. Citi	zen of W	/het Country?	
- A2 Not	12472	Ridgel	y Road			216				USA			
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Be Completed	15	15. Decedent Specify only highes	's Education	nd)	16a. Dece	dent's Usual	l Occupa	ation	vorkina	16b. Ki	nd of Bu	siness/Industry	
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17 00		2 Cremetion on 5 Other (Sp			oring Gr				12/23/	2000	Dent	on, Mary	vland
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State Registrar

31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture DEC 2 2 2000

B. Spars



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3 Time of Death Physician ember 12,2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster general Hospital Variation of the Mindal 1 Year arro ount 7. Age (In) last birthday) Birthplace (Stata or Foraign Country) 5. Social Security Number Funeral Months Days Hours 215-16-9480 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show traumatic avant, the Medical Exeminer must be notified at 1 Yas 2 No Funeral Director Nestminster arrol 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Mill U.S.A. 14. Race - American Indian, Black, White, etc. 21157 Lagad 12. Was Decedenl Evar in U,S Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yas 2 No Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Be Completed by Year or Datas: White 3 Widowed 4 □ Divorced "natural". 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Health end Mental Hyglene. Int: If itam 27 Is marked other than ' Elementary/Secondary (0-12) Cottege (1-4or 5+) Cashier 2 12 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Nettie dward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) -ucabaugh Mill Rd., Westminster MD. 21157 Date 20c. Location - City dr Town, State Evelyn leak, daughter 20a. Meybod of Disposition 0 1 Burial 2 □ Cremation 3 □ Removal from State Evergreen Memorial Bardens 12-18-00 Finks burg, MD 4 ☐ Donation 5 ☐ Other (Specify) 32. Name and Address of Facility Schapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Rd. Westminster MD 23a. Pert1/Enter the disease, or compliantons that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each ine. Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 Probably 4 SUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No this certificate 25. Was case referred to medical axaminar? 26. Plece of Deeth (Check only ona) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After ! 1 Naturat 5 Pending or Attanding within 24 hours after death. To the Funeral Diractor: Al 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. completely

Registrar

DEC 1 4 2000 DHMH 16 Rev 6/95

29b. Signature and title of cartifier

31. Data filed (Month, Day, Year)

Enrico A

Giangeruso, m) 32. Registrar's Signatura

30. Name and addrass of person who completed cause of death (Item 23a) Type, Print)

arroll

29d. Date signed (Month, Day, Year)

2000

Westminsto

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 1 2 3 6 8

	Certificate of Death	Reg. No.	42000
Dhusisian	Decedent's Neme (First, Middle, Last)	2. Dete of Deeth Month Dey	3. Time of Deeth
Physician /Medical	KAINOND TAKKISH DAKNES	DEC. 15,	2000 5 AM
Examiner	4e Facility Neme (If not institution, give street end number) 4b. City, Town		ounty of Deeth
			ARROLL
Funeral Director		Hrs. 8. Date of Birth (Month, Dey, Yeer) 8 / 25 / 1909	9. Birthplece (State or Foreign Country) MARYLAND
po a m	10e. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits
Many Many	MD. CARROLL WESTMINSTER		1 ☐ Yes 2 ☒ No
or 28a-f s be notified	10e. Street and Number 10f. Zip Code	10g. Citize	on of Whet Country?
Part of the Cale	723 HOOK RD. 21157	USA	A
20 s after dea aminer m	11. Meritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 ☑ Merried 11 □ Yes 2 ☑ No If Yes, specify: 12. Was Decedent Ever in U,S. If Yes, specify Cuben, Mexican, F 1 □ Yes 2 ☑ No Specify:	Puerto Rican, etc.)	. Race - American Indian, Bleck, White, etc.
5-0020 72 hours a natural, o dical Exam	3 ☐ Widowed 4 ☐ Divorced Year or Detes:	40h Wins	WHITE
21215-0 ed within 72 ha ygiene. we then "natur it, the Medical. Connolested	15. Decedent's Education 16e. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired)	f working	of Business/Industry
2121 d within grane. rr than . The Ma	Elementery/Secondery (0-12) College (1-4or 5+) OWNER & MECHANIC		LERSHIP
ind Spelled		Name (First, Middle, Maiden S	
O Dagu o	JOHN WILLIAM BARNES CARR	IE ELIZABETH	PARRISH
Mary 42 shoot 5 s mark 1 is mark traument	19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number of	or Rurel Route Number, City or	Town, Stete, Zip Code)
M party	LUCY D. BARNES - WIFE 723 HOOK RD., WE	STMINSTER, M	D. 21157
Ore Service Se	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	Dete 20c. Loca	ation - City or Town, State
L. Pages 1 tment of Hs tant: if lien tjary or oth	1 ☑ Buriel 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify) PROVIDENCE CEMETERY	12/18/00 GAM	BER, MD.
all miles	21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility	FLETCHER FUN	ERAL HOME
00 23558	Laws (Latter 254 E. MAIN ST	., WESTMINST	ER, MD. 21157
Physician	23a. Pert1. Enter the disease, or copolications that caused the deeth. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or respiratory errest,	Approximete Intervel Between Onset end Death
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth) e.	7	10 day
12301010	Due to (gree a consequence of): //		
Day is the	b. Cardiae Hyppyllmid		5 mm
58760, cata be asscuted physician and the burial-transit			4 years
0 8 9	resulting in deeth) Lest		9/
Box eath cert attending			
tha dy the scheduled with	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.		ae contribute to the cause of death'
that that > Q		1	No 3 Probably 4 Unknow
Il Records, P.O. Box The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use Completed by Physician/N		24a. Was en eutops performed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
Vital Rec		1 ☐ Yes 2 🗷	
Vital sicien: The cartificate irector, pa		of Deeth (Check only one)	10 100 2010
Of VIta Physician: this carifical ral director,	examiner? 1 Yes 2 No	ing Home 5 N Residence 6	Other (Specify)
Physicarthis arthis		28d. Describe how injury	
Division or Attending R after death. Director: After d in by the funer ertification:	1 XNaturel 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigation M 1 Yes 2 No.		
Division or Attendi after death. Director: A d in by the feetificati	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and City or Town, Stete)	Number or Rurel Route Number,
Se a district	Building, div. (Spacify)		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end graduate in the composition of the compos	pleca, end due to the cause(s) a occurred at the time, date end p	nd menner es steted. eleca, end due to the cause(s)
Within to the comment	29b. Signeture end title of certifier 29c. License number	29d. Date	signed (Month, Dey, Year)
	Johns Middlicka D25443	12/	15/2000
	30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)	104	
	JOHN W. MIDDLETON 688 POOLE RD. WESTMINST	ER, MD. 2115	7
State	31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture		
Registrar	DEC 18 2000 Server & Sports	- 1 - 1 - 1 - 2 W	



Plea	se Type oi	Print In E	Black In	delible	e Ink	. Assu	ıre Al	l Coples	Are Legil	ble.	
	State	of Marylan		artmen			and M		giene U	0 4	2369
1. Decedent'a Name (First, Middl	e, Last)							2. Dete of Dec	eth		3. Time of Death
David Richa	rds Ben	nett						Month	17 20	Year	12:57pm
4a Fecility Name (If not institution	a give street end n	umber)				4b. City, To	wn, or Lo	cation of Death			TC .) Pm
						TT					
Carroll Count 5. Sociel Security Number	6. Sex	7. Age (In vrs.) If Under	1 Year	Wes-		8. Date of Birt	h	9. Birthplac	ca (Stete or Foreign
116-28-3349	XXM 2□F		6 Yrs.	Months	Days	Hours	Min.	(Month, Da Mar 2		Country)
Usual Residence of Decedent			0					Mar Z	4 1934		Minn
10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d	. Inside City Limits
MD Car	roll	II	niont	OWn							1 ☐ Yes 2 □ No
10e. Street end Number	1011	1 9	1110110	10f. Zip	Code				10g. Citizen of V	Vhat Country	n
3481 Unionto	wn Road			100	211	58			USA		
11. Marital Status		cedent Ever in U	S 13	Was Dece			ain? (Spe	ecity Yes or No		e - American	Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	led 1X Yes	Forces?			city Cub		, Puerto	Rican, atc.)		k, White, etc Whi	
15. Deceden	t's Education		16e. Dece	dent's Usu	el Occup	oation			16b. Kind of Bu	siness/Indus	stry
(Specify only highe	st grede completed		(Give	DO NOT u	rk dona se retire	during mos d)	t of work	ing	U.S.		5 10 10 10
Elemantary/Secondary (0-12)	Collega	(1-4or 5+)	Air	Wing	Of	fice:	r		Marine	e Cor	p
7. Father's Neme (First, Middle,	Last)							(First, Middle,	Meiden Sumem		
Orville Benr	ett					Hone	e El	izahet	th Sant	ford	
19a. Informent's Name/Ralations			19b Mail	ing Addrass	S (Street	T.			er, City or Town,		ode)
Patrece Benr		e e							own, MI		
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		- 01-1-	Plece of Disponentery, cre	osition (Nematory or o	me of other ple	ca)		Date	20c. Location -	City or Town	
21. Signature of Funeral Service	Licensee					ess of Facilit					
10 V	411								nd Char		001155
23a. Partif. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	th. Do not an	ntar the mod	de of dyi	ng, such as	cardiac o	or respiretory a	tminste rrest,	A	D 2 1 1 5 7 pproximete itarval Batween conset end Death
Immediate Ceuse (Final disease or condition resulting In deeth)	e. <u>M</u>	etas				CA	uce	R		1	5days
		Due to (d	or as a conse	equence of):							
Sequentially list conditions, if eny, leading to immediate	b	Due to (d	or as a c <i>on</i> se	quenca of):		25				1	
if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	c										
that initiated events resulting in death) Lest		Due to (d	or as a conse	quence of):							
	d										
Part II. Other significant condition	ons contributing to	death but not ras	ulting in tha	underlying o	cause di	ven in Part i		23b. Did	tobacco use co	ntribute to t	he cause of death?
			•					1×	Yes 2□ No	3 Probe	bly 4 Unknow
									an eutopsy ermed?	aveil	e eutopsy findings able prior to pletion of cause ath?
								10	Yes 200No		Yes 2□ No
25. Was casa referrad to madica						26. Place	a of Daat	h (Check only o	one)		
examiner? 1 ☐ Yes 2 Ø No	Hospital:	Inpatient 2	ER/Outpatie	ent 3 D	DA OI	her			denca 6 □Oth	er (Specify)	
27. Manner of Death 1 Death 5 Pendir	28a. Dat (Mo	a of Injury onth, Day Year)	28b. Time of Injury		28c. Inju Wo				how injury occur		
2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Pla	ce of Injury - At h ding, atc. (Specil	oma, farm, a					28f. Location (City or To	Street and Numb wn, Stete)	per or Rurel I	Route Number,

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Depertment of Haelth and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-7 show any injury or other traumatic event, the Medical Exempter must be notified at once.

Baltimore, Maryland 21215-0020

Funeral Director

To Be Completed by

Sequentially list cor if eny, leading to im cause. Enter Under Ceuse (Disease or that initiated events resulting in death) L Part II. Other signif

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires thet the death cartificate be executed within 24 hours after death.

Very the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the turnerial director, page 2 should be deteched for use as the burlai-transit completely filled in by the turnerial director, page 2 should be deteched for use as the burlai-transit

Division of Vital Records, P.O. Box 68760,

determined 4 Homiclde Certifying Physician: To the best of my knowledge, daeth occurred at the time, dete end pleca, and due to tha causa(s) and mennar as atated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and placa, and dua to the cause(s) and mannar statad. 29a Certifier

29b. Signature and title of certifie

Galund Tis

29c. License number 031660

STUNER

NR

29d. Date signed (Month, Dey, Year) 12/18/2000

WESTAMETER M.

21157

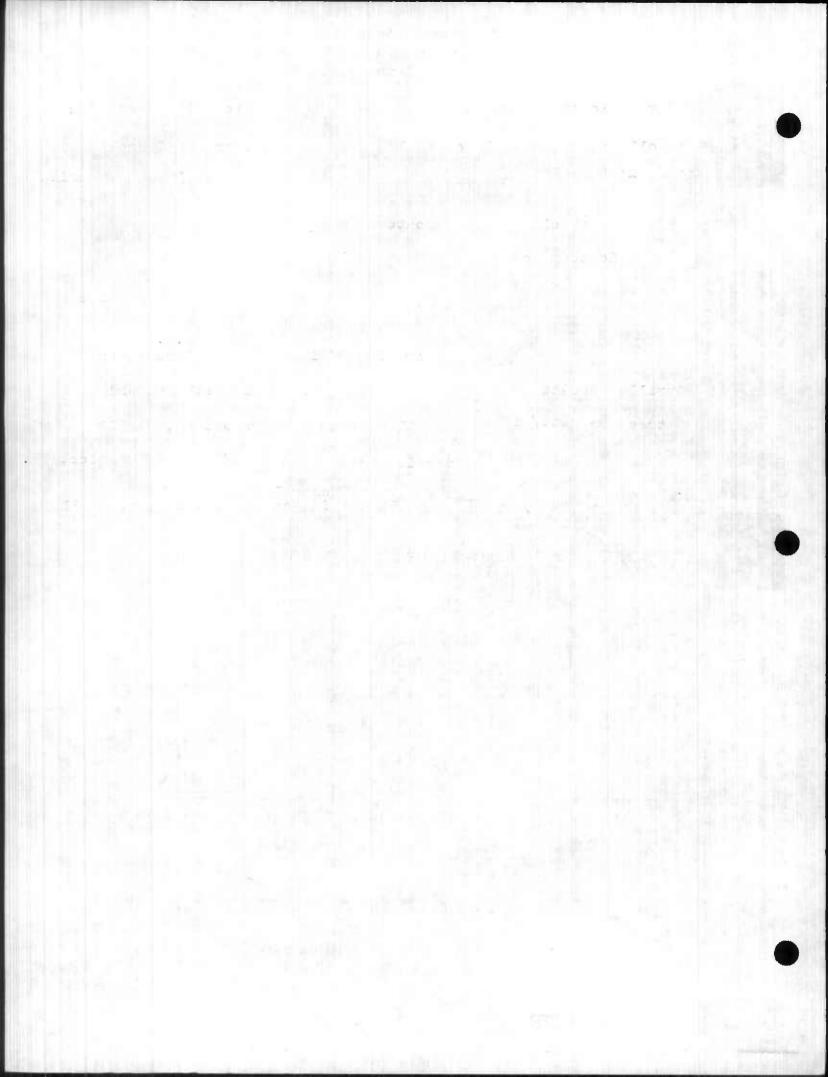
30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

HOMAS GALVIN 31. Date filed (Month, Dey, Year)

DEC 19 2000

32. Registrer's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10 42370

			Ce	ertificate of	Death		g. No.	9201	
Physician	Decedent's Name (First, Middla,					2. Date of Death	Day	Year 3. Time of Do	
/Medical	betty A. Burt					Dec. 19	1		-m-
Examiner	4a Facility Name (If not institution,				4b. City, Town, or L		4c. County		
48	Mallard Bay Care) If Under 1 Yaar	Cambrio		Dor	chester	
Funeral Director	5. Social Security Number 218–20–7536 Usual Residence of Decedent	4DM ONE	(In yrs. last birthday 73 Yrs.	Months Days		8. Data of Birth (Month, Day, Feb. 2,	^{Year)} 1927	9. Birthplace (State or F Country) Maryland	-oreign
deeth with the Meryland rms 23a or 28a-f ehow rms to notined at	10a. State 10b. County		10c. City, Town or L	ocation	5.0			10d. Inside City	-
o Mer	Maryland Doro	chester	M	adison				1 ☐ Yes 2	No
vith the Me or 28a-fe pernounced	10e. Street and Number			10f. Zip Code		10	og. Citizen of V	What Country?	
th wi		Road		2164	18		U.S	.A.	
off. or he by Fu	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forcas? 1 Yes 2 N If Yes, Give Year or Dates:	ver in U,S. 13	Was Decedant of If Yes, specify Cub	Hispanic Origin? (Sp an, Mexicen, Puerto Specity:	ecify Yas or No- Rican, atc.)		e - Amaricen Indian, ck, White, etc. White	
ygiene. Nor than "natural, the Wadcal! Completed	15. Decedent's (Specify only highast)	Education	16a. Dec	edent's Usual Occu	pation during most of work d)	ina	16b. Kind of Bu	usiness/Industry	
5 1 5	Elementary/Secondary (0-12)	College (1-4or 5-	F)						
be filed within itel Hygiene. d other than event, the Manavent, the Manavent, the Manavent, the Manavent item.	11			Homemaker		4F	Own He		
Sec S	17. Father's Name (First, Middle, La	ist)			Sadie	e (First, Middle, N	raiden Suman	10)	
d 2 should lith end Meni			100-14-1	lin . Addmin (Otro			City on Town	Chata Zin Code)	
	19a. Informant's Name/Relationship				tand Number or Rul LSON Rd.,				
Healt Fm 2	R. Hubert Burton 20a. Mathod of Disposition	i/ husband	20b. Place of Disc	position (Name of				City or Town, Stata	
8 2 2 0	1 Burial 2 □ Cremation 3		cemetery, cri	ematory or other pla					
parmit. Pe Departmen Important: eny Injury once.	4 Donation 5 Other (Spe			•	Cemetery	12-22	CHUE CH	Creek, MD	1111
parmit. Pege Department of Important: If eny Injury or page.	21. Signature of Funeral Service Li	arises /		22. Name and Addr Curran—Bro	omwell Fur	neral Hom	e, P.A		
45.00	Soduntar	ad BOM	well	808 High S	St., Cambr	idge, MI	21613		
	shock, or heart talker List or	omplications that ceused by one cause on each line	the death. Do not ea e.	nter the mode of dy	ing, such as cardiac	or raspiratory arre	est,	Approximate Interval Batwe Onset and De	9 9 0
Physician /Medical	Immediate Cause (Final		1	1:	110 0	8 %. 0.			0.111
Examiner	Immediate Cause (Final disease or condition rasulting in death)	a. #77	teriosc/c	e rd nc	Heart-	1)/ (eace		year	
	A STATE OF THE PARTY OF THE PAR	000	Dua to (or as a conse	equance of):					_
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eath certificate be executed etrending physician end for use as the burial-frensit clary/Medical Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as a conse	equence or):					
Sicial of Duri	Cause (Disease or injury that initiated events	c	No to for so a conse	augana of):					
ficate be physicials the burner edical	resulting in death) Last		oua to (or as a conse	quanca orj.				1	
nding use a		d							
d for Icla	Part II. Other significant condition:	contributing to death but	t not resulting in the	underlying cause a	iven in Part f	23h Dld to	hacco use co	ntribute to the cause of	death?
that the death cert ed by the ettendin deteched for use Physiclar/M	atti, outer argument conditions	s contributing to death bu	thot resulting in the	underlying cause g	WOITHIT ATC.		a 2 No	3 Probably 4'S-U	
es the left per left se left s									
The lew requires that the death certificate be executed tate has been signed by the ettending physician and page 2 should be deteched for use as the bural-trensit Completed by Physician/Medical Exami						24a. Was as perform	n autopsy ned?	24b. Were autopsy fine available prior to completion of ceu	
hes by ye 2 s								of death?	
						1□ Ye	s 2 No	1 ☐ Yes 2 ☐ N	0
Physicien: The rhis certificate ral director, peg	1-	Hospital:			hoe	th (Check only on			
this aldi		1 LI Inpatiar	t 2 ER/Outpatie	ent 3LI DOA	40 Nursing H	ome 5 Reside			
To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affer I completely filled in by the funer Medical Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Data of Injun (Month, Day)	Year) 28b. Time Injury	Wo	ork? Yes 2 No	28d. Describe ho	w injury occur	red	
or Attending effector: Affei Director: Affei in by the fune ertification	3 Suicide 6 Could no detarmin	28a. Place of tnju building, atc.	ry - At homa, farm, s (Specify)	treet, factory, office		28f. Location (St. City or Town		ber or Rural Route Numbe	9 <i>1</i> ,
pital ours ours of Illed		Physician T-the bases	Constitution des	sh annuar dat sha s	in a data and along	and die to the or	out of and m	anner an attitud	
n 24 hours n 24 hours ne Funerel pletely filled	29a. Certifier 1 Tertifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examination and/or i						
within 2 To the comple		10/11/	10	29c. Licen	se number			ed (Month, Day, Year)	
	13	of the			D 47°	124	12 -	20-00	
	30. Name and address of person wi	no completed cause of de	ath (Item 23a) (Type	e, Print)					
	NOMAN TO	TANNY 30	U AURUR	A STRI	CET CA	MIRIDE	1 M	1 2/6/3	
State	31. Date filed (Month, Day, Year)		r's Signature						

DHMH 16 Rev 6/95

State

Registrar

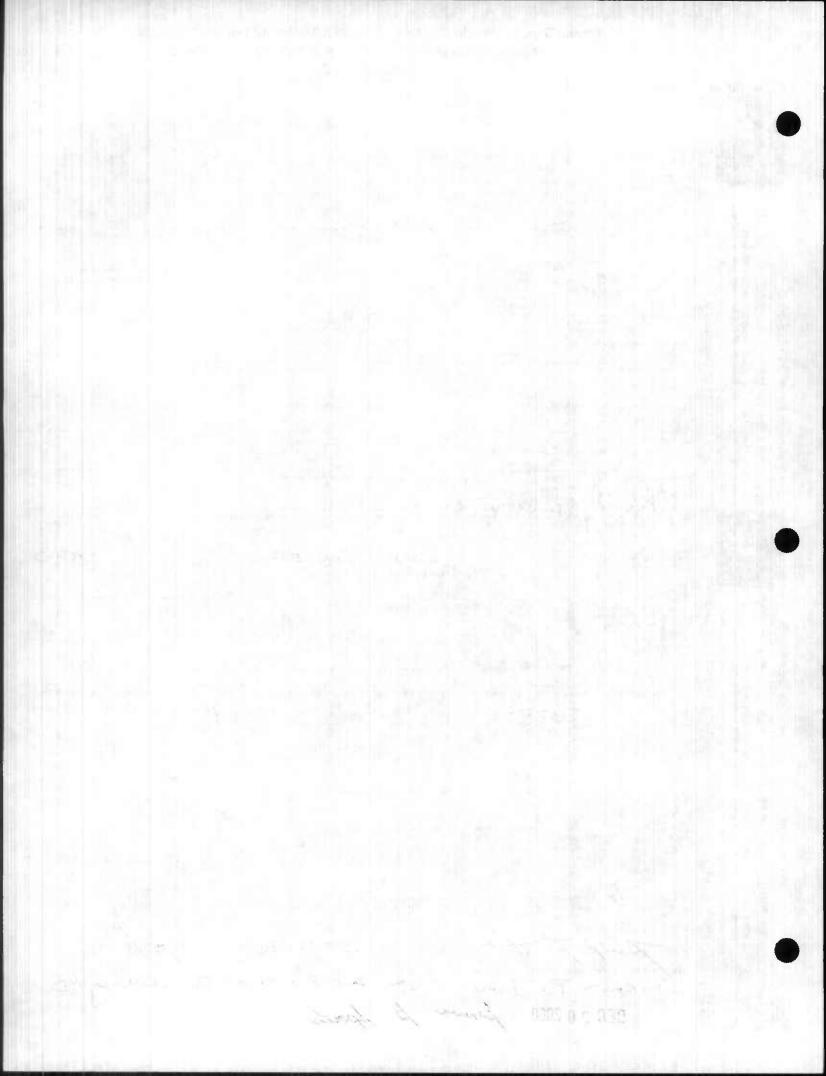
DEC 21 2000

the my filler DEC 21 2000 James & April

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Contificate of Death

Physician	A December None (Class Added)									
/Medical		CINTYRE WHIT	E BU	RR		Oh: Tours as l	2. Dete of Dea Month 12	Dey 17 20	Year OO	3. Tima of Deeth 3:45 p
Examiner	4a Facility Neme (If not institution, g	and Autobach - and			4	b. City, Town, or l				
M. H.	205 White Stree			day) If Under	1 Vans	Salisbu		Wico		
Funeral	5. Social Security Number 6	Sax 7. Age	(In yrs. last birth	Months		Hours Min.	8. Date of Birt (Month, De		9. Birthp	elece (Stete or Foreigntry)
Director	214-10-6420	10 201	83 Y	rs.			1/14/	1917	Mar	yland
2 .	Usuel Residence of Decedent 10s. State 10b. County		10c. City, Town	or Location					1	0d. Insida City Limit
anyla short dat			roc. Ony, rount	OI LOOMION					1	1 ZYas 2 □ N
The M The f	MD Wicomi	co	Salisb		4					2 7 5
vith the Ma t or 18e-f a be notified Director	10e. Street and Number			10f. Zip	Code			10g. Citizan of V	Vhat Cour	ntry?
		t		2.	1804			USA		
her death v r hams 23s kiner must Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U,S.	13. Was Deced	ent of Hi	spenic Origin? (S	pecify Yes or No-	14. Race	e - Americ k, White,	an Indian,
P. Hope	1 Never Merried 2 Married	1 TYas 2X No		1 Yes 2			0 7 110411, 010.,			010.
D EN C		If Yes, Give Year or Detes:		ILI Tes 2	LANO	Specify:		Specify		hite
ad within 72 ho yglene. we than "nature 4, the Medical.] Completed	15. Decedent's		16a. C	Decedent's Usua	l Occupa	tion	dian	16b. Kind of Bu	siness/Inc	dustry
Med o	(Specify only highast s Elementery/Secondery (0-12)	College (1-4or 5+		lite. DO NOT us	e retired,	uring most of wor	King	owner/c	nora	tor
the the	7	College (1-40) 54		auticia	n			Primros	e Be	auty Salo
		st)				18. Mother's Nan	ne (First, Middla,			****
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and Management	19a. Informant's Name/Ralationship		19b. I	Mailing Address	(Street e	and Number or Ru	-	er, City or Town.	Stete, Zip	Code)
	Betty "Jo" Lewis			-		ury Dr.,				
Tand Health am 27 other tr	20e. Method of Disposition	(Disposition (Nem			Date	20c. Location -		
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Physician /Medical Examiner	Immediate Cause (Final disaasa or condition resulting in death)	a	Lu	Ne	CAI	UCER			1	Onset end Death
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	Ceuse (Disease of Injury	D	ue to (or as e co	nsequence of):						
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certificate nding physuse as the	resulting in death) Lest	d	not resulting in	the underlying or	euse give	en in Part I.	23b. Did	lobacco use col	ntribute to	o the cause of dea
hat the death certificate dby the attending physiolached for use as the Physician/Medic	Part II. Other eignificant conditions	d	not resulting in t	the underlying co	euse give	en in Part I.	0	tobacco use con Yee 2 No		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death December 14, Year Dey 8:05 AR Elenora Barnes-Sutton 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 5108 Addison Chapel Onks Prince George's Bond If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 F 579-14-8031 90 -13 - 1910Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1k Yes 2 No Prince George's Chapel Oaks 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 5108 Addison Rd 20743 U.S.A. 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Nurse Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Lucy Robinson Grady Barnes 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Jones 5108 Addison Rd Chapel Oaks, MD 20743 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/22/00 Maryland National Laurel, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Rd. Landover, MD 20785 23a, Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) CARLIDVASCULAR Disease Atheroscherotic Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

P.O. Box 68760, Division of Vital Records. to the Hospital or Attending Physician: Physician

/Medical

Examiner

Funeral

Director

"natural", or frame 23a or 28a-f ahow

In Pages 1 and 2 should be filed within 72 hours after from at 0 Heath and Mental Hygiene.

Text if Item 27 is marked other tean "netural", or ite item or other traumatic event, in a sedical factor.

Physician

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Examiner

Physician/Medical

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Be Completed

Medical Certification: To

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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						24a. Was en eutopsy parformed?	24b. Were eutopsy tindings eveilable prior to completion of cause of deeth?
25. Was case referre	d to medical				26. Placa of D	eath (Check only one)	
1 Yes 2 N	io	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 D	OA Other: 4 Nursing	Home 5 Residence 6 □0	ther (Specify)
27. Menner of Death 1 ☑ Neturel 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	28d. Describe how injury occ	urred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Pleca of Injury - At h building, etc. (Specia	ome, farm, stree	et, factor	y, office	281. Location (Street end Nur City or Town, Stete)	nber or Rurel Route Number,
						ca, end due to the cause(s) and i curred at the time, date and place	

29c. License number

State Registrar

30. Name end address of parson who completed cause of death (Item 23a) (Type, Print) Sylvester SALVERLER 7001 Hosp, Tac

Drine Cheverly

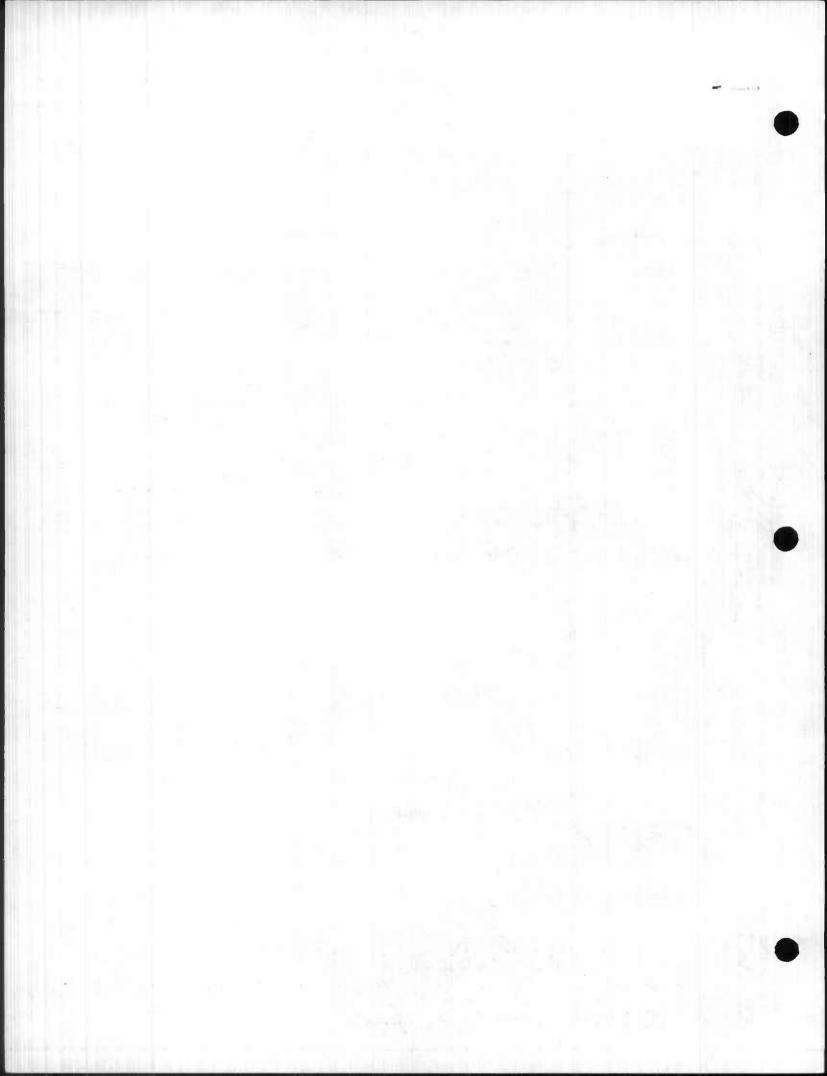
29d. Date signed (Month, Day, Year)

31. Dete filed (Month, Day, Year) 2 0 2000

29b. Signeture end title of certifier

32. Registrar's Signetyre

Do



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year Barnett Sally December 16 2000 249 AM 4b. City, Town, or Location of Death 4c. County of Death 4a Fscility Name (ff not institution, give street end number) Southern Maryland Hospital Prince George's Clinton ff Under 1 Yeer If Under 24 Hrs. 7. Age (fn yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Days Hours 1□ M 2♥ F 49 Yrs March 14, 1951 Kentuckey 405 74 7017 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes XX No Maryland Prince George's Clinton 10e. Street and Number 10g Citizen of What Country? 10f. Zip Code 9503 Small Drive United States 20735 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status 1 Yes 2XXIIIo 1 Never Married 3 Married Specify: White 1 ☐ Yes 200 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Kindergarten Teacher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Orme James C. Allison 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9503 Small Drive, Clinton, Maryland 20735 Randy C. Barnett (HUSBAND) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dec 19, 200 20a. Method of Disposition

2 □ Cremation 3 □ Removel from State 20c. Location - City or Town, State Stonewall Memory Gardens Manassas, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service License Alexandria Ferry Road, Clinton, Maryland 20735 ours utrany 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Metabolic encephalopathy disease or condition resulting in deeth) Wecks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or es e consequence of): 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 4 Hiknown renal facture. cervical cancer 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ovarian cancer 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

P.O. Box 68760. Division of Vital Records, a after deeth.

I Director: After do in by the funer Hospital 24 hours

Physician

/Medical

Examiner

Funeral

Director

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Certification:

the Maryland

Baltimore, Maryland 21215-0036

Chronic Anemia. 25. Was case referred to medical 1 Yes 2 11 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Watural 5 Pending investigation 1 Tyes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certified Pure. tulipo

29c. License number HN H0042445

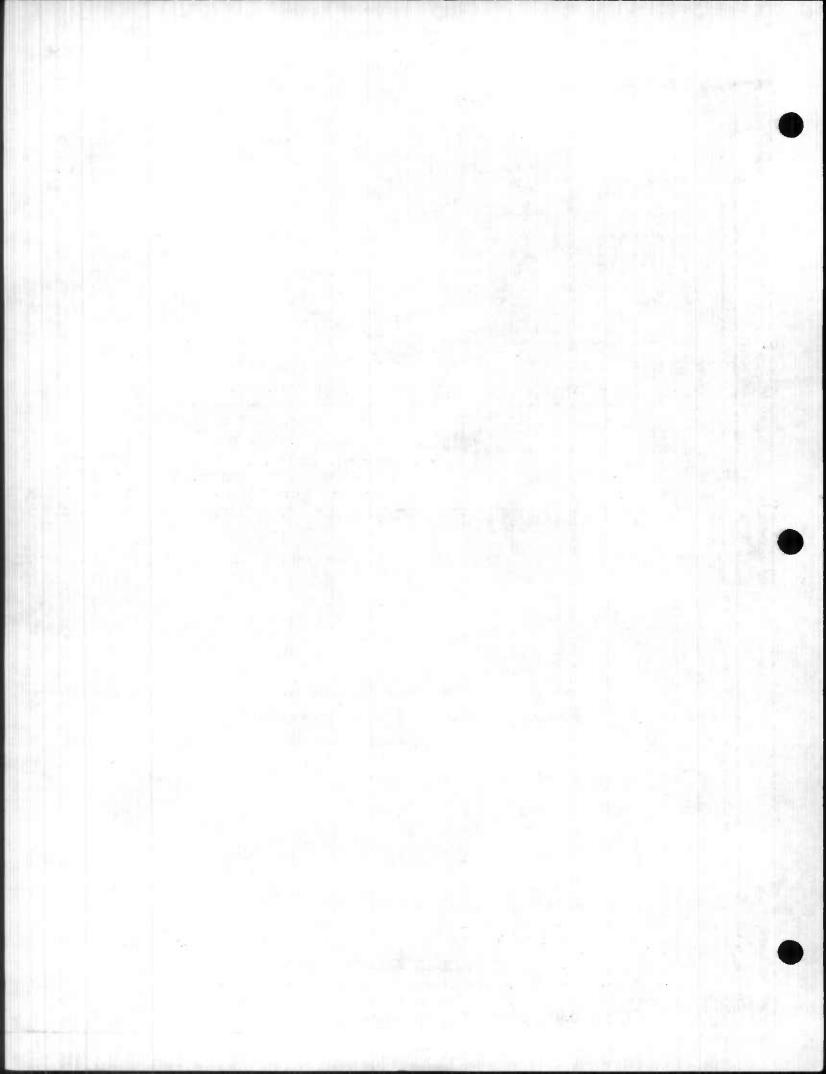
29d. Date signed (Month, Day, Year) necember 16,2000

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Michael Pimentel, no 601 Post Office Road, 1A Waldorf Maryland

State Registrar

31. Date filed (Month, Day, Year) DEC 2 0 2000 32. Registrar's Signature

To the To the



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UU

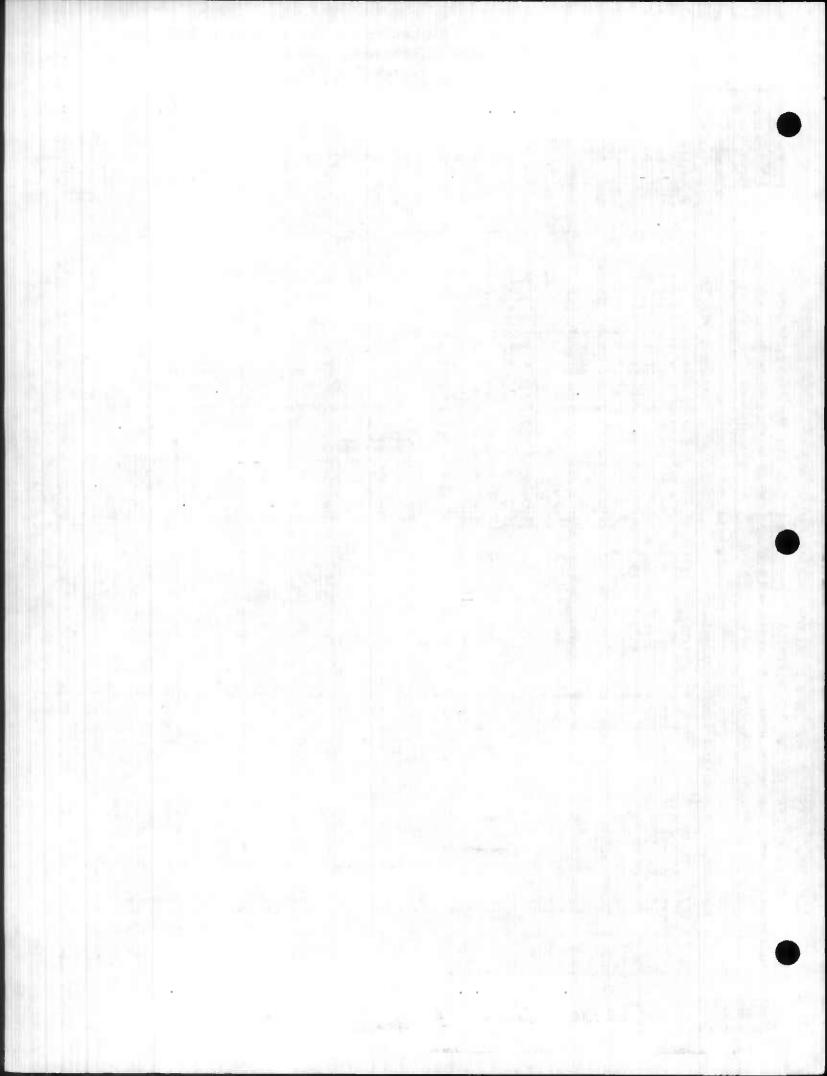
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Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) Month **Physician** BRIGHT 18, 2000 ROBERT I. E. December 20:57pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner BETHESDA MONTGOMERY HOSPITAL SUBURBAN Hours Min. 8. Date of Birth (Month, Day, Year)
April 8, 1 If Under 1 Yaar Birthplace (State or Foreign Country) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 10XM 20 F Yrs. 90 Director 212-39-5892 Liberia Usual Rasidenca of Decedent with the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County or Nerna 23a or 28a-f ahow traumatic avant, the Medical Examiner must be notified at N☐ Yas 2☐ No Chevy Chase Director Md. Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 20815 Monrovia, Liberia 4601 North Park Avenue Funeral death 14. Race - American Indian, Black, Whita, atc. 12. Was Dacedant Ever in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status 1 Yas 2 No If Yas, Give Yaar or Datas: filed within 72 hours after 1 Nevar Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 ☐XNo Specify: Black Specify: Completed by 3 Widowed 4 Divorced "netural", 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Collega (1-4or 5+) Elementery/Secondary (0-12) Agriculture Businessman / Farmer 18. Mother's Nama (First, Middla, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental Htant: If itam 27 is marked out William O. Davies-Bright Nancy M. Ashley 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2: Department of Health at important: If item 27 is any injury or other traconce. Chevy Chase, Md. 4601 North Park Avenue Edith L. Bright / Wife Baitimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 1-6-01 Palm Grove Cemetery Monrovia, Liberia 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licenşaa 22. Nama and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Washington, DC 20002 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** immediata Causa (Final disaasa or condition rasulting in daath) /Medical INTRACEREBRAL HEMORRHAGE Examiner Dua to (or as a consequence of): Examiner RIGHT-SIDED SUBDURAL HEMORRHAGE Sequentially list conditions, if any, laading to immadiate ceuse. Entar Underlying Cause (Diseasa or injury that Initiated avants rasulting in daath) Last Due to (or as e consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably 4 Unknown à MALIGNANCY OF PROSTRATE Be Completed by 24b. Wara eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐XNo 25. Wes case refarred to medicel 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospitat: 1X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Medical Certification: To 28c. Injury at Work? 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Panding 1 Yas 2 No Invastigation 2 Accidant Diractor: 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 281. Location (Street end Number or Rural Routa Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and dua to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and dua to the ceuse(s) and manner stated. within 2 To the 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifier carrina December 18, 2000 D21662 30. Nama and addrass of person who complated ceusa of death (Item 23a) (Type, Print) Wilhelmina G. Camina, M.D. 4912 Adrian Street Rockville, Md. 20853 31. Date filed (Month, Dey, Year) DEC 2 2 2000 32. Registrar's Signature State Registrar Sports

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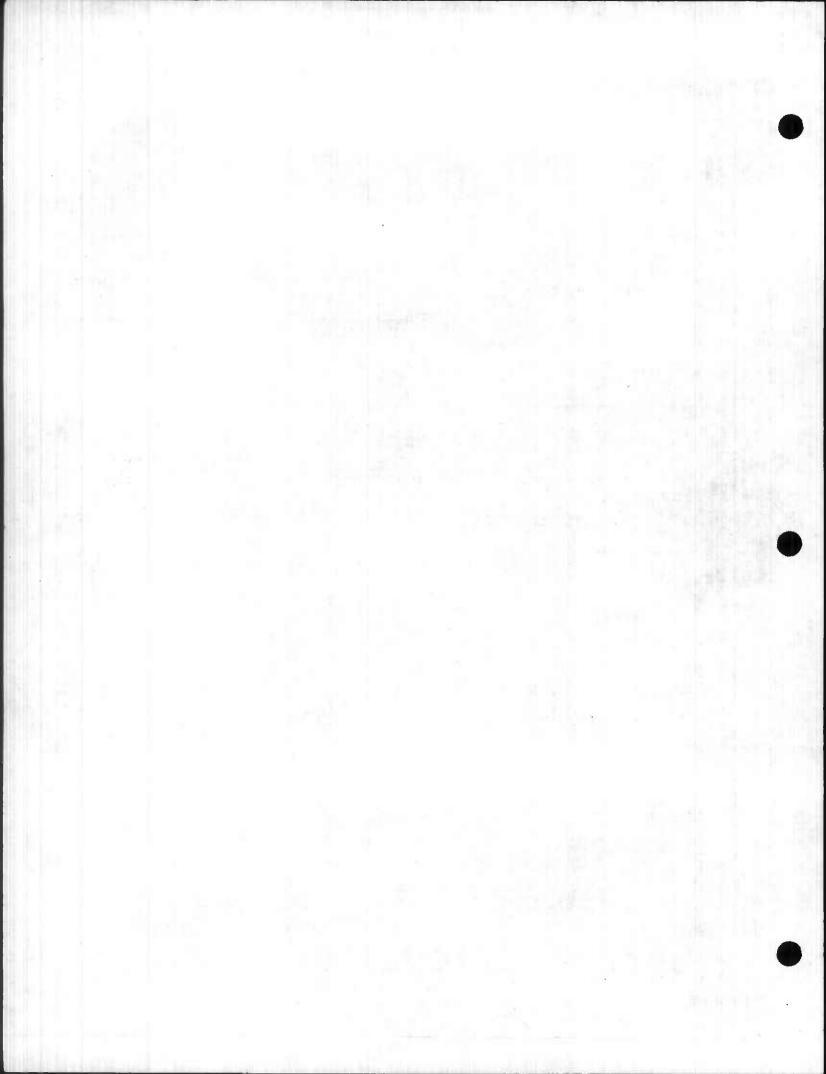
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	Decedent's Nama (First, Middle, Last)		001	incate	01 2	Death	2.	Data of De	Reg. No.		3. Time o	of Death
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/Medical	An English Mamo (Mant institution size .				14	b. City. To	wn, or Locati	cember		2000 unty of Death		p.m.
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for death of the same than a 23 with a mark	11. Marital Status	12. Was Decedent Ever in L Armed Forcas?	J,S. 13.	Was Deceder If Yas, specify	of of H Cube	ispanic Origin, Mexicen	gin? (Specify , Puerto Ric	Yes or No an, etc.)		Race - Amer Black, White		
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72 Table	15. Decedant's Edu (Specify only highest grade		(Give	dent's Usual (kind of work	done o	durina mosi	t of working		16b. Kind o	of Business/I	ndustry	
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To To	19e. Informent's Name/Relationship (Ty		19b. Meilii	ng Address (S	Street					wn, State, Z	ip Code)	
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Hem other	20a. Method of Disposition	20b.	Place of Dispo	sition (Name	of		· T	Date		on - City or		0701
Pages net if the ary or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ort Lain				12/:	22/200	0 Bren	twood.	Mary	land
permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If then 27 is marked other any injury or other traumatic event, I gate.	21. Signatura of Funaral Service License	1	1	2. Name and 7			y Gasc	h's I	Tuneral	l Home	, P.A.	
	23a. Part1. Entar tha disaase, or compli	cations that caused the dea								Lie, M	Approxima	
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/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Myocardial	Infarc								3 Day	S
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deeth certificate e ettending phys ad for use as the	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying ceu	ısa qiv	en in Part I	. 1	23b. Dld	tobacco use	contribute	to the cause	of death?
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he law le hes age 2								10	Yas 2XIN	lo .	I ☐ Yes 2[] No
	25. Was cese referred to medical					26. Place	of Death (C	Check only	one)			
Physician: this certific ral director.	1 Yes 2N No	lospital: 1 Inpatient 2	☐ ER/Outpatie	nt 310 DOA	Oth	er: 4 Nu	rsing Home	5 ☐ Res	idence 6 🗆	Other (Spec	cify)	
g Ph.		28e. Date of Injury (Month, Day Year)	28b. Time o	1 280	. Injur Wor	y at	280	f. Describe	how injury o	ccurred		
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tal or Attending P is effer deeth. al Director: After led in by the funer.	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At I building, etc. (Spec	nome, farm, st ify)	reet, factory, o	office		28f		(Street end Nown, Stete)	lumber or Ru	irel Route Nu	m <i>ber</i> ,
To the Hospital or Attending in within 24 hours effer deeth. To the Funeral Director: After completely filled in by the funeral Director.		sician: To the best of my kn- ner: On the basis of examin end manner stated.										(s)
To the complete of the complet		1	1	29c. L	Licens	a number			29d. Data s	igned (Monti	h, Day, Year)	
P > P 0	1 K (A	Alan	lun	0	1	U.	204	9	121	21/0	00	
7	30. Name and address of person who ee	mpleted cause of death (Ite	om 23a) (Type,	Print)		-	/		1. 0	1		
	TAM C. A	FEW 6	502	- K	E	17/6	ser.	BIL	t1 13	16		
State Registrar	31. Date filed (Month, Day, Year) DEC 2 2 ZUUU	32. Registrar's Sign	d.	bout	31	13C	DDF)しど	· c	50 2	6. 4:	37

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Clara W. Breeding 2:00 p.m. December 20 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Larkin Chase Nursing Home Prince George's Bowie If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 25 F 222-03-1501 83 Director Dec. 17, 1917 Delaware Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or liens 23s or 28s-f show the Medical Examiner must be notified at 1√ Yes 2□No Maryland Prince George's Lapham Directo 2 10e. Street and Number 10f. Zio Code 10o. Citizen of What Country? 9318 Fontana Drive 20706 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Hygiana. 12 Homemaker Own Home 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be and Mental marked Blanche Howard Joseph A. Woerner le m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important; if then 27 is in any injury or other traun once. William Allison - Friend 5903 84th Avenue, New Carrollton, Maryland 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 3 Other (Specify) Darlington Cemetery 12/23/2000 Darlington, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service License 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Atherosclerosis - Cardiovascular Disease Years Examiner Due to (or as a consequence of): Physician/Medical Examiner Chronic Obstructive Pulmonary Disease Years ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yee 2 No 3 Probably 4 Unknown signed t þ 24b. Were autopsy findings available prior to been si 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2√ No 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funera Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier

Division of Vital Records. MM

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

29b. Signature and title of certifier Lish ar ong, MD 29c. License number

29d. Date signed (Month, Day, Year) 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

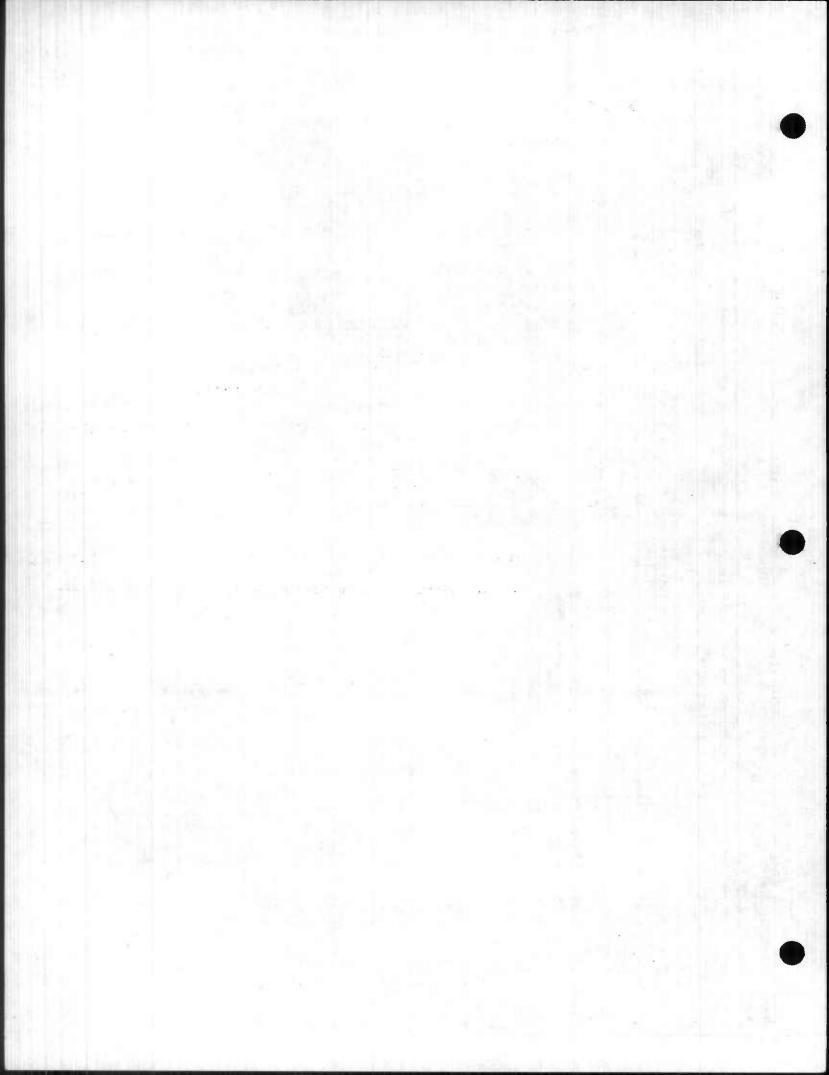
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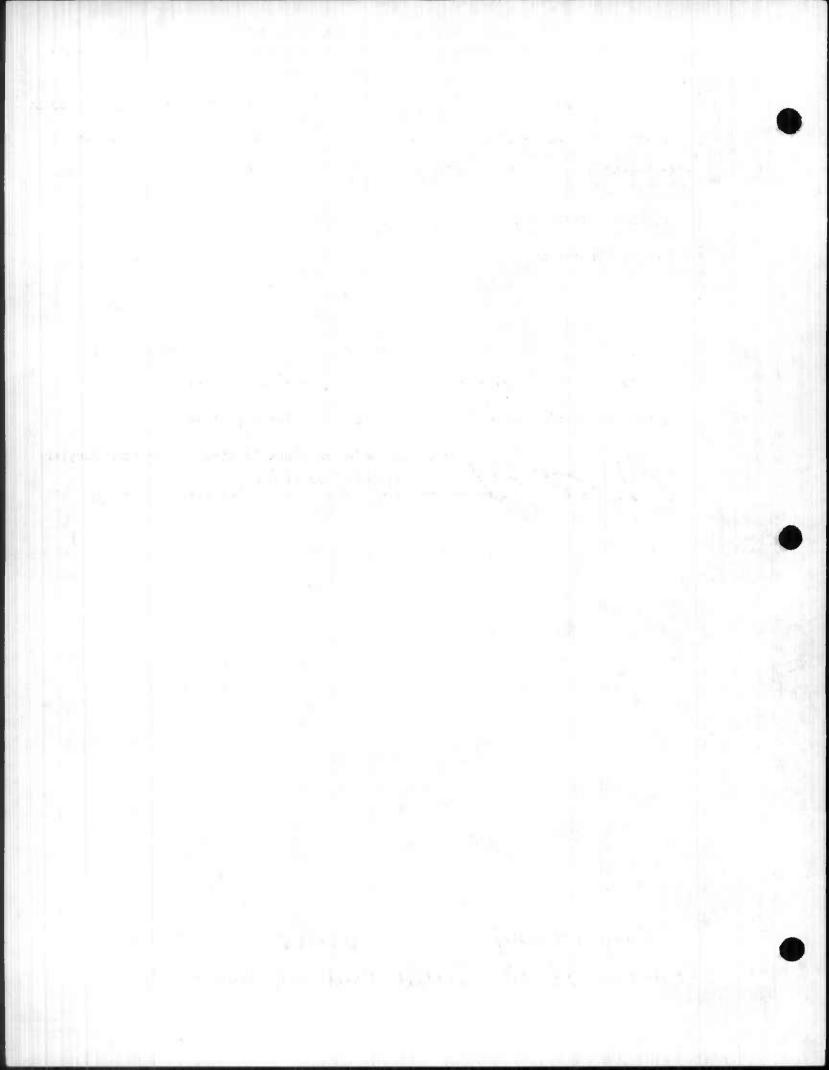
32. Registrar's Signature Geneva

Goods! **ORIGINAL**



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Director	9	10e. Street end Number	igron		10f. Zip C		10	a. Citizen of	Whet Country?	
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	0	Edward Sherida	an Dunahugl	1		Ada L	ee Griffi.	th		
		19e. Informent's Name/Relationship	Type, Print)	19b. Mailin	g Address (Street and Number or R	ural Routa Number,	City or Town,	State, Zip Cod	e)
		Pat Dunahugh/Sis	ter In Law	P.C	. Box	159 Fall	ing Water	s, WV	25419	
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State of Maryland / Department of Health and Mental Hygiene 1 4 2 3 7 8

1. Decedant's Nama (First, Middla, L.	est)		e of Death	2. Data of De		3. Tima of Death
Kenneth	Bynum Jr.			Month Decemi	ber 03.	Yaar 2000 4:49 P.M
4a Facility Nama (If not institution, gi	va street and number)		4b. City, Town,			
	Hospital Cente			-4		ce George's
577-80-8089		Mantha		Ain. (Month, Da	th ay, Year) 18,195	Birthplace (Stata or Foreign Country) Wash.D.C.
	10c Ci	ty Town or Location				10d. Inside City Limits
Md Prince		*				1 ⊠ Yas 2 □ No
	dy Road	10f. Zip	20785		10g. Citizan of V	What Country?
11. Marital Status 1 ☑ Nevar Married 2 ☐ Married 3 ☐ Widowad 4 ☐ Divorced	12. Was Decedant Evar in U Armed Forcas? 1 ☐ Yas 2 ☑ No 11 Yas, Giva X Yaar or Datas;	If Yas, spec		(Specify Yas or No uarto Rican, atc.)	Specify	e - Amaricen Indian, ck, Whita, atc. Black
15. Decedant's E (Specify only highast gr Elamantery/Secondary (0-12) 12	ducetion ada com <i>platad)</i> College (1-4or 5+)				16b. Kind of Br	• Gas
Kenneth	Bynum Sr.			Gwendol	yn H	arris
	Trainovar nom Stata	Place of Disposition (Name of	na of thar placa) Morial Pk	Data 12/13		City or Town, Stata
		22. Nama an	d Addrass of Facility	Hunt Fu	noral	Homo
Francis B.	Hunt	908 K	ennedy St			
23a. Part1. Entar tha disaasa, or com shock, or haart tellure. List only Immediata Causa (Final disaasa or condition rasulting in daath)	a Multiple I	njuries	a of dying, such as cer	diac or raspiratory a	rrast,	Approximata Intarvel Batween Onsat and Death
	b					
f any, leading to immadiata ceuse. Entar Undartying Causa (Disease or injury that initiated events resulting in death) Last	cDua to (o			- 3		
Part II. Other significant conditions of	contributing to death but not ras	ulting in the underlying o	eusa givan in Part I.			ntribute to the cause of death
				24a. Was	an autopsy ormed?	24b. Wara autopsy tindings availabla prior to complation of ceuse of death?
				165	Yes 2□No	ty⊠Yas 2□ No
25. Was casa ratarred to medicel axaminer?	Hospital:		Othor			
1 XYes 2 No 27. Menner of Death 1 Netural 5 Pending	1 ☐ Inpatiant 2 ☐ 28a. Dete of Injury (Month, Dey Year)		A 4 Nursin Bc. Injury at Work?		dance 6 Oth	
	12-03-00	1600p M	1 ☐ Yas 2 ☐ No	motorcu	cle acc	ident
des Consolin		yma tarm ettaat factory	office	281. Location	Street and Numb	per or Rural Routa Number
3 Suicida 6 Could not b 4 Homicide datermined	building, alc. (Specify	street		Landor	er Mel	Per or Rural Routa Number Dr.
3 Suicida 4 Homicide Could not b datermined	28a. Plece of Injury - At he building, atc. (Specify specify) yelclan: To the best of my kno- niner: On tha basis of examinal and mannar statad.	sireet wiedge, death occurred a	it the time, data and ol	ace end due to the	cause(s) and me	nnar as stated
	4a Facility Nama (III not institution, ging Prince George's) 5. Social Sacurity Number 577-80-8089 Usual Residence of Decedant 10a. State 10b. County Md Prince 10e. Street and Number 7727 Normane 11. Marital Status 1 Nevar Married 2 Married 3 Widowad 4 Divorced 15. Decedant's Especify only highast gride in the state of th	4a Facility Nama (If not institution, giva street and number) Prince George's Hospital Cente: 5. Social Sacurity Number 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. 7. Aga (In yrs. 4. 2 Usual Residence of Decedant 10a. State 10b. County Md Prince George 10e. Street and Number 7727 Normandy Road 11. Marital Status 12. Was Decedant Evar in Uarmed Forcas? 11. Marital Status 12. Was Decedant Evar in Uarmed Forcas? 12. Was Decedant Evar in Uarmed Forcas? 13. Widowad 4 Divorced 15. Decedant's Educetion (Specify only highest grada complated) Elamantery/Secondary (0-12) 17. Father's Nama (First, Middle, Last) Kenneth Bynum Sr. 19a. Intormant's Name/Relationship (Type, Print) Linda Bynum Sister 20a. Mathod of Disposition 18 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funaral Sarvice Licensaa 19a. Internation and Sacurity one ceusa on aach lina. Immediata Causa (Final diseasa, or complications that caused the deat shock, or haart teilure. List only one ceusa on aach lina. Immediata Causa (Final diseasa, or complications that caused the deat shock, or haart teilure. List only one ceusa on aach lina. Immediata Causa (Final diseasa or condition rasulting in death) 23a. Part Entar tha diseasa, or complications that caused the deat shock, or haart teilure. List only one ceusa on aach lina. Due to (conditions of the surface of	4a Facility Nama (If not institution, give street and number) Prince George's Hospital Center 5. Social Sacurity Number 577-80-8089 1D3M 2DF 42 Yrs. 42 Yrs. Usual Residence of Decedant 10a. State 10b. County Md Prince George 10c. City, Town or Location Mnorths 10a. State 10b. County Md Prince George 10c. City, Town or Location 10d. Zip 1727 Normandy Road 11. Marrial Status 12 Was Decedant Evar in U.S. Amed Forcas? 12 Novar Married 12 Was Decedant Evar in U.S. Amed Forcas? 13. Was Decedant Evar in U.S. Amed Forcas? 14 Yas, spectify and or Detains 15. Decedant's Educetion (Specify only highest grade completed) 16a. Decedant's Completed) 17b. Feather's Nama (First, Middle, Last) 17c. Father's Nama (First, Middle, Last) 17d. Father's Nama (First, Middle, Last) 18d. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass 12c. Nama an 18d. Decedant's Educetion	4a. Facility Nama (If not institution, give street and number) Prince George's Hospital Center 5. Social Sacurity Number 5.77-80-8089 1000 2 F 7. Aga (In yrs. last birthday) 5. The Sacurity Number 7. Aga (In yrs. last birthday) 1000 2 F 42 Yrs. 1000 2 F 100 2 F 20 20 20 20 20 20 20 20 20 20 20 20 20	As Facility Name (if not institution, give street and number) As English Name (if not institution, give street and number) As English Name (if not institution, give street and number) As English Name (if not institution) As English Name (if n	As Facility Name (troit institution, give street and number) Prince George's Hospital Center S. Social Sacurity Number 5. Social Sacurity Number 5. Social Sacurity Number 6. Sac

State

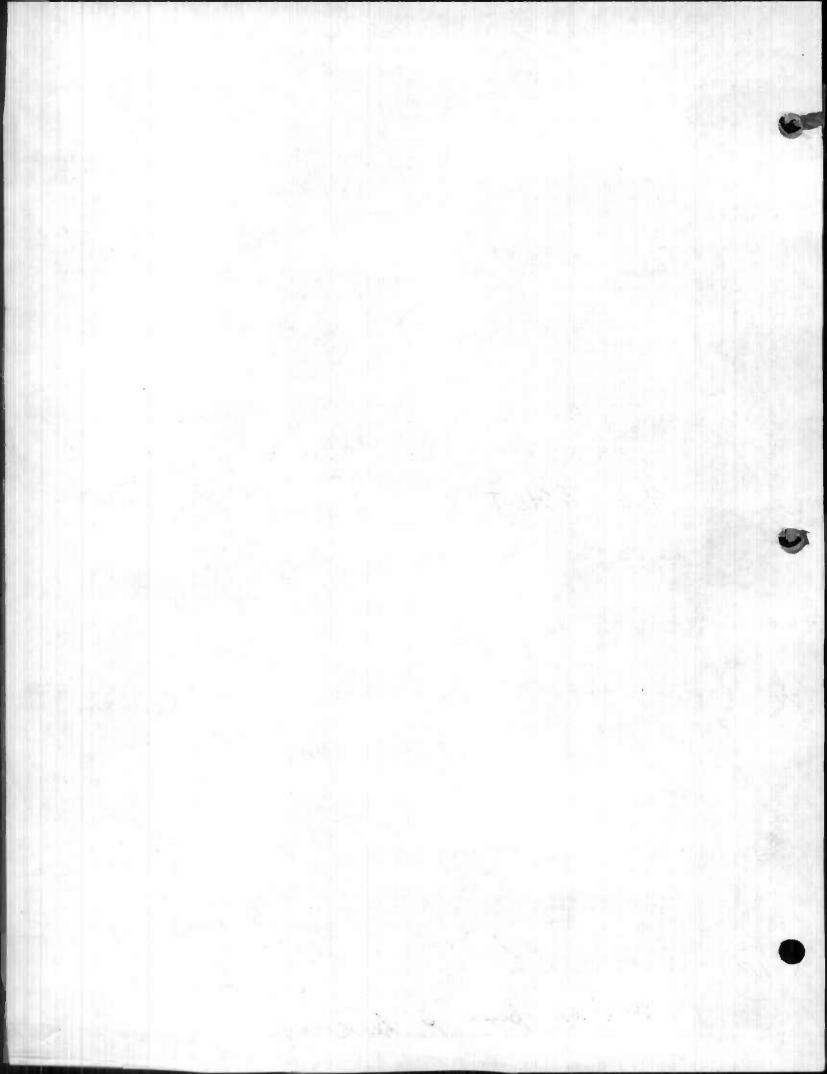
32. Registrar's Signatura

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ADMEND ITEM: #15, 16A, 16B PER F.H. G793 3-17-01 WR of Death

Real No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** BRIMER HAT.T. NELLIE 15 12 2000 22:26 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Worcester 1915 Snow Hill Road Stockton If Undar 24 Hrs. Hours Min. 8. Data of Birth Month Day Year 6/20/1919 Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Funeral 1□M 2\ F Months Davs 81 Yrs. Director 229-05-5891 Usual Rasidence of Decedant Virginia 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Stockton Worcester 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 21864 USA 1915 Snow Hill Road 234 Funerai 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Maryland 21215-0020 6 1 Yas 2 No Specify: Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Il Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEWIFE 11 i. Peges 1 and 2 should be filed with ment of Heelth and Mentel Hygie tant: If Item 27 is marked other taluny or other traumatic event, to 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Mamie Taylor Ashton Hall 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) P.O. Box 101, Girdletree, MD 21829 J. Hamilton Brimer (husband) Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Depertment of Important: If any injury or pace. 12/19/00 Girdletree, MD 4 ☐ Donation 5 ☐ Othar (Specify) Springhill Cemetery 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility
Holloway Melson Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 103 Linden Ave., Pocomoke City, MD 21851 Approximata Intarval Between Physician Interior cleratic Hoart Visease Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Physician/Medicai Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequenca of): Dua to (or as a consequence of) Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributs to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Renal Failure 2 tive Heart Freibune 24b. Wara sutopsy findings svailable prior to completion of cause of death? Completed 24a. Was an autopsy Wicheter rellitus 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital or Attending Physician: Be 25. Was casa referred to medical 26. Place of Death (Chack only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Phasidanca 6 Othar (Specify) 1 Yas 2 100 Certification: To 28a. Date of Injury (Month, Day Year) 27. Menne of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After Division 1 Naturat 5 Panding investigation after death. 1 Yas 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Spacify) 4 - Homlcida within 24 hours a To the Funeral C complately filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier Medical (Check only one) To the 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. Licansa number ho completed cause of yearth (from 238) (Type, Print)

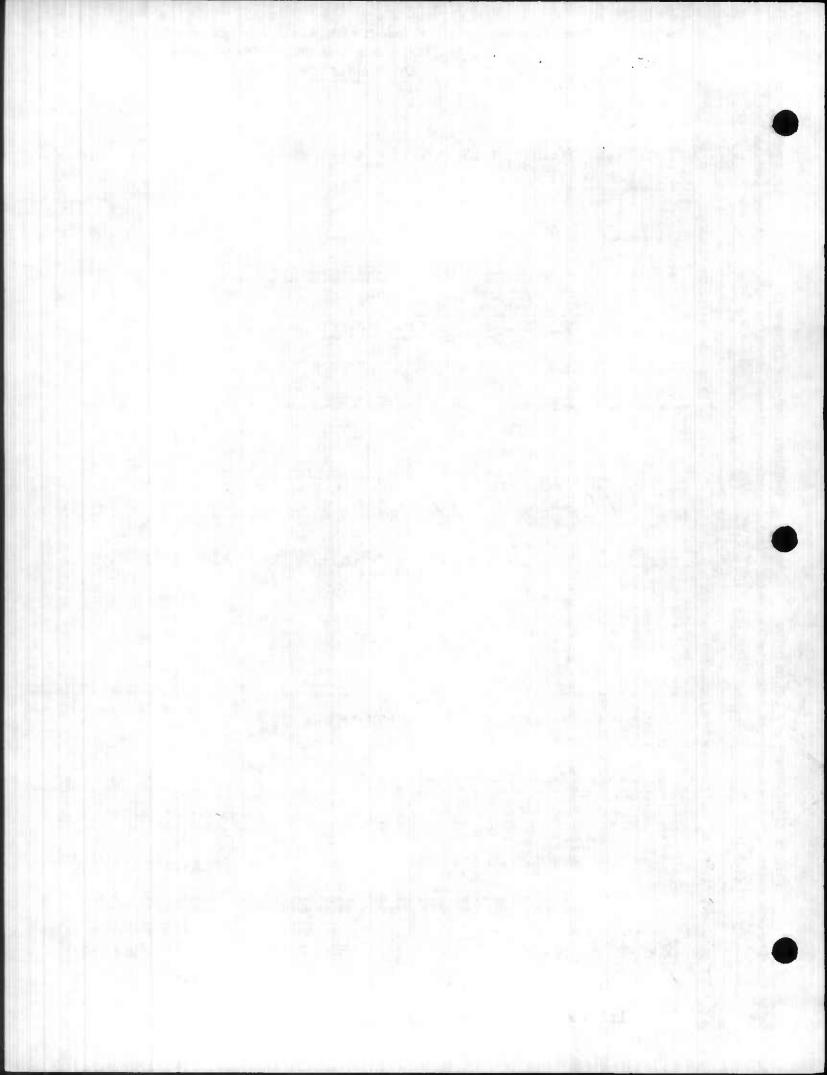
DHMH 16 Rev 6/95

Registrar

31. Data filed (Month, Day, Year)

DEC 1 9 2000

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

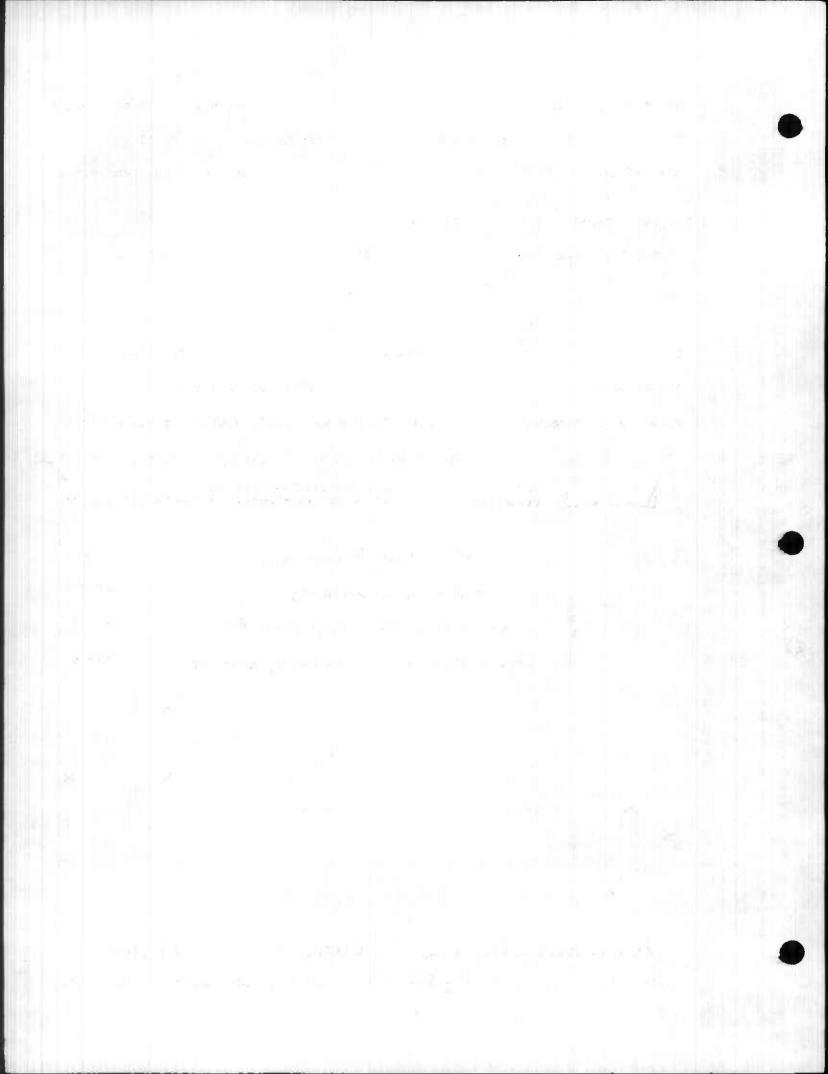
State of Maryland / Department of Health and Mental Hygiene 0 4 2 3 8 0

\$25\$ amend item 26 per md G791 1/12/01 yf Certificate of Death

	1. Decedent's Nama (First, Middla, L.	ast)		oranouto c	, Douth	2. Data of Dea			3. Tima of Death	
Physician /Medical	John Patrick		Sr.			Decembe		000	8:27 an	
Examiner	4a Facility Nama (If not institution, gi				4b. City, Town, o	or Location of Death	4c. County			
			e (In yrs. last birthda	(v) If Under 1 Ya					ice (State or Foreign	
Funeral Director		1 ∆ M 2□ F	76 Yrs.	Months Da	ys Hours M	s. B. Data of Birth (Month, Day Dec. 13	, 1923	New	y) York	
yland	10a. Stata 10b. County	A PROPERTY.	10c. City, Town or	Location				10	d. Inside City Limits	
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death with the Manyand ms 23s or 28s-f show Linust be notified at neral Director	10e. Streef and Number			10f. Zip Coo	ia		10g. Citizan of V	Vhat Countr	ry?	
ath w	5014 E. Prestoi			211				ed Sta		
5 22 5	11. Marifal Sfatus 1 Nevar Married 2 M Married	12. Was Decedant Armed Forcas? 1 2 Yas 2 1 If Yas, Giva	No	If Yas, specify ((Specify Yas or No- arto Rican, atc.)	Blac	e - Amarica ik, Whita, at Whit	lc.	
hour hour	3 Widowed 4 Divorced 15. Decedent's 8	Yaar or Datas:	WW II	cedant's Usual Oc	cupation		16b. Kind of Bu			
	(Specify only highast gr	rada complatad)	(Gi	va kind of work do DO NOT usa ra	na during most of v	vorking	TOD. THIRD OF DE	501165511165	Johny	
d within giene.	Elementary/Secondary (0-12)	College (1-4or 5	War	cehouse v	vorker		Food	d Dis	tribution	
Maryland 21215-0 d 2 should be filed within 72 ho th and Mental Hygiena. 7 is marked other than "naturn traumatic event, tra Heolical TO Be Completed	17. Fathar's Nama (First, Middla, Las Patrick Barke					lama (First, Middla, an Wohr	Maidan Sumam	a)		
	19a. Informant's Name/Ralationship Mr. Robert Lee Bo					Rural Routa Numbe				
Baltimore, semit. Pages 1 ar separtment of Heamportant: If item iny Injury or otherwise.	20a. Mathod of Disposition	Demonstrate State	20b. Placa of Dis	position (Nama o	f place)	Data	20c. Location -	City or Tow	m, Stata	
Page nent ment ury o	1 Burial 2 A Cramation 3 4 Donation 5 Othar (Spec		Greenmo	unt Crem	atory		Baltimo	re, M	aryland	
Balti Pemit. Departrimportu Importu any Inje	21. Signature of Funaral Sarvice Lica	nsee	al Home,	Inc						
m goess	Mare 1 - 19	Pe	e Baltim	ore, ma	rylan	d 21213				
Physician	23a. Part1. Entar tha disaasa, wood, shock, or haart failura. List on	residents that caused residents a on each lie	I tha daath. Do not a na.	antar tha moda of	dying, such as card	liac or raspiratory an	rast,		Approximata Intarval Batween Onsat and Death	
/Medical Examiner	Immediata Causa (Final disaasa or condition rasulting in death)	a/Myoc	andiAL	Info	und					
	Dua to (or as a consequence of).									
min ansit	Sequentially list conditions	b. Ceng	Dua to (or as a cons	sequence of):	11000	19 10	4,00			
ox 68760, C. rentificate be executed and use as the bunial-transit in/Medical Examiner	Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated events	0								
68760, physician as the buria	that initiated events rasulting in death) Last									
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death cert death cert eath cert at a ster usa		u.								
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law requires been a 2 should npieted						- perior	mear	com of d	pletion of causa aath?	
I Relay The lay page 2						1 🗆 Y	as 20 No	10	Yas 20 No	
f Vital Re- yalclan: The lav sis cartificate has director, paga 2 To Be Comp	25. Was casa rafarred to modical axaminar?				26. Placa of £	Daath (Chack only o	na)			
T di di	1 X Yas	Hospital: 1 Inpatia		ient 3□ DOA	Other: 4 Nursing		enee 6 0th)	
sion o tending Ph eath. for: After th the funeral cation:	27. Manner of Death 1 ☑ Natural 5 ☑ Panding	28a. Data of Inju (Month, Da	ry Year) 28b. Time Injur		Injury at Work?	28d. Dascribe h	low injury occur	red		
Orvision or Attending latter death. Director: Attant lin by the fune extification	2 Accidant invastigation 3 Suicida 6 Could not	be	ury - At homa, farm,		1 ☐ Yas 2 ☐ No	28f Location (5	Straat and Numb	per or Rural	Routa Number.	
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Division of To the Hospital or Attending P. within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		hysicien: To the best of miner: On the basis of and manner ste	axamination and/or							
Within the complete of the com	29b. Signature and titla of certifier	/ 4		29c. Lic	cansa number	1	29d. Date signe	d (Month, D	lay, Year)	
- s - o	hall k	wah	20	1	37136		121	15/	00	
12	30. Nama and addrass of person who	complated causa of d	aath (Itam 23a) (Typ	e, Print)	2110	01 1	2	160	Baltin	
10	Bowhara	Kircher	5(1)	1 Loc	in Rave	en Blodig	Duite	412	212	
		an Defiate	ar's Signatura				-			

					Ce	rtifica	te oi	Death	1		Reg. No.			
		1. Decedent's Neme (First, Middle, L	ast)		7.5					2. Date of D	eath		3. Tir	ne of Deeth
Physi /Mod		Theodore H. Brow	vn							Month	er 9	Year 2000	19	15 P
/Med Exam		4a. Fecility Name (If not institution, g.	ive street end num	nber)				4b. City, To	wn, or L	ocetion of Dee	th 4c. Coun	ty of Death		
		Calvert Manor He		e Cente	er			Risi			Ceci	11		
Funera Directo		216-05-3958	Sex 1MM 2□ F	7. Age (In yrs. 95	lest birthday, Yrs.	Months Months			Min.	8. Dete of Bi (Month, D May 14	rth ey, Yeer) 1, 1905	Cou	intry)	tate or Foreig vania
pu »		Usual Residence of Decedent 10a. State 10b. County		100 Ci	ity, Town or L	nontine								
he Marylen 88-f show	Director	Maryland Cecil			Lkton								1 🗆	de City Limits Yes 2 No
th with the 23s or 2		10e. Street end Number 3216 Old Elk Ned	ck Road				p Code 921				10g. Citizen o			
21215-0020 4 within 72 hours efter death with the Maryland piene. I then "natural", or frems 23s or 28s-f show the Wolcal Example must be notified at	by Funeral	11. Marital Status 1 □ Never Merried 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Yes If Yes, Give Yeer or Da	ces? 2X No e	J,S. 13.			Hispenic Ori ban, Mexican Specify:		ecify Yes or No Rican, etc.)	Spec	ace - Ameri lack, White, hity: Wh		an,
5-0 72 ho	Completed	15. Decedent's I	ducetion		16e. Dece	dent's Usu	al Occi	upetion	4 =6ad		16b. Kind of	Business/Ir	ndustry	
within 7	ple	(Specify only highest g	College (1	-4or 5+)	life.	DO NOT	ise retir	e during mos red)	it of work	ang				
202	00	11			Туре	esette	er				Print	ing		
Maryland 2 d 2 should be filed th end Mentel Hygie 7 is merked other traumatic event, it	Be	17. Father's Neme (First, Middle, Las	t)					18. Mothe	er's Nem	e (First, Middle	, Maiden Sume	ime)		
larylan 2 should be and Mentel 5 marked o	To	Elwood Brown						Cla	ra E	. Ander	cson			
Maryla d 2 should th end Mer T is merke	1	19a. Informent's Name/Reletionship	(Type, Print)		19b. Maili	ing Addres	s (Stree	et end Numb	er or Rur	al Route Numb	er, City or Tow	n, Stete, Zi	ip Code)	
C = N L		Theodore H. Brow	vn/Self		3216	01d	Elk	Neck 1	Road	, Elkto	n, Mary	land	219	21
altimore, I		20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Spec		Stete	Place of Disponentery, cre	metory or	other pi		1	Date 2/13/00	20c. Location			
Baltimor permit. Pages Depertment of h Important: If ite	MINE	21. Signature of Funeral Service Lice	ensee		H	icks	Home		ty uner	als, P.	Α.			
Rame I		23a. Pert1. Enter the disease, or cor shock, or heert failure. List only	- Aug	SS	-						ton, Mar	:yı.and	Approx	
Physician /Medica Examine		Immediate Ceuse (Finel disease or condition resulting in deeth)	θ		or es e conse					_		- 1	Seve Days Mont	
oute rans	Examiner	Sequentially list conditions, if eny, leeding to Immediate	b	Due to (or es e conse	quence of)	: 43	Para	15					
760, to be execut ysiciun and e burial-tran		cause. Enter Underlying Cause (Diseese or injury that initiated events	c. I	diopat	mic or es e consec	Two-	امحار	cytop	mia	Purpi	NG		Year	s
Box 68 sath certifica attending ph for use as th	n/Medical	resulting in death) Lest	d. Char			,	2	mona	~	Disea	e		Year	'S
death o	Icia	Pert II. Other significent conditions	contributing to de	ath hut not res	sulting in the I	ınderivina i	rausar	ilven in Pert I	1	23h Did	tobacco uee c	ontribute (o the ce	use of death
P.O. hat the d by th detachy	y Physician		contributing to dec	atti bot not res	saking in the c	indenying .	vause g	jiven in reit i			Yes 2⊠No			
DIVISION OF VITAI RECORDS, for Attending Physician: The law requires if after death. Director: After this certificate has been signed of in by the funeral director, page 2 should be	Completed by										en eutopsy ormed?	6/	veileble p	psy findings prior to n of cause
The last page 2	E									10	Yes 25 No	1	□Yes	20 No
DO. TO	BeC	25. Wes case referred to medical					-	26 Place	of Dogs	h (Check only				GOS THO
A to a direct	0	examiner?	Hospital:	patient 2	ER/Outpetie	nt 3 D	04 0				idence 6 🗆 O	th (C	16.1	
0 H 10	-	27. Menner of Death		-	28b. Time o						how injury occi		ny)	
VISION Attending r death, ector: Alte by the fune	Certification:	1 SNaturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not	De Diseas		Injury	М		Yes 2	No		Street end Nun		ra / Pausta	Atumbar
DIVISI outpital or Atten hours after deal meral Director. by filled in by the		4 ☐ Homicide determined	buildin	of Injury - At h g, etc. (Specia	fy)					City or To	wn, Stete)			, 70(1100),
To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hystcien: To the b miner: On the bas and menn	sis of examine	owledge, deet etion end/or In	h occurred vestigation	et the	time, date en opinion, dee	d plece, th occur	end due to the red et the time,	ceuse(s) end n date end plece	nenner es s , end due t	steted. to the cer	use(s)
To Tage	Σ	29b. Signature end title of certifier				29	c. Licer	nse number			29d. Date sign	ed (Month,	Day, Ye	er)
10		than and ordinary	arie P	anglar.) (X	05019	15		12/1	3 00		
10		30. Name and address of person who					. 1		101	/ Charre	Mend - 1	Da5 -		D
, ,		31. Date filed (Month, Dey, Yeer)				10/10	71	~~ C	-(7(Snauna	Marie	ray10	L, M.	υ.
S	tate	DEO 1 0 2000	52. He	gistrer's Slane	erure		,							

DHMH 16 Rev 6/95



2000

1. Decedant's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death **Physician** 23, Charles Carnobas December 2000 Harrison 8:55 AM /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Solomons
If Under 24 Hrs. Calvert 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) Min. 1₩ 2□ F Months Days Hours 205-30-2511 62 Yrs. March 2, 1938 Pennsylvania Usual Rasidance of Dacedant 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No St. Mary's Hollywood Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20636 United States 25335 Pinto Drive Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 1 (2) Yas 2 □ No 1 Yas, Giva Yeer or Detes: 1 OS Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, White, atc. 11 Marital Status 1 Nevar Married 2 Married 1953 White Baltimore, Maryland 21215-0020 1 Yas 2 No Specify. p 3 XWidowed 4 ☐ Divorced 1983 Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Deputy Program Manager US Government permit. Peges 1 end 2 should be filed v Department of Health and Mental Hygien Important: If itsm 27 is marked other th any Injury or other traumatic avent, the page. 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Father's Nama (First, Middle, Last) Thomas Peter Carnobas Minerva Hepler 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip CodeMaryland 19a. Informant's Name/Ralationship (Type, Print) 45770 Church Drive, Apartment 202, Great Mills, 20634 Charles H. Carnobas, Jr. Son 20b. Place of Disposition (Nama of cematery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete January 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Removal from Stata Arlington National Cemetery 4 ☐ Donation ▲ ☐ Othar (Specify) 10,2001 Arlington, Virginia 22. Nama and Address of Facility Brinsfield Funeral Home, P.A., 22955 Hollywood Rizzo MO1114 Road, P.O. Box 279, Leonardtown, Maryland 20650 23a. Part1. Enter the disassa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or hi art failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician Immediate Cause (Final disaasa or condition resulting In death) /Medical **Examiner** Physician/Medical Examiner Sanamius 0 Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Disease or injury thet initiated evants resulting in death) Last Box 68760. pMO CV Due to (or es e consegue nce of): nov P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate hes been signed by page 2 should be detac P Division of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 2 1 No 1 Yas 2 No 1 Yes Physicien: 25. Was casa referred to medical 26 Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To After this 27. Manner of Death 1 Natural 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. tnjury at Work? or Attending 5 Pending invastigation s after deeth.

J Director: Aff 1 Yas 2 No 2 Accidant 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 6 Could not be detarmined 3 Suicide 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homicide within 24 hours of To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a Certifian completely To the 29c. Licanse number 29d. Data signed (Month, Dav. Year) 296. Signature and title of certifier 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) Manoj Panwala, M.D., Prince Frederick, Maryland 20678 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura



State Registrar

DHMH 16 Rev 6/95

DEC 29 2000



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year **Physician** Gilbert Anthony Combs December 25, 2000 10:05 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 21689 I Exington Park

If Under 24 Hrs. 8. Date of B.

Hours Min. (Month, Month, Mont Hancock Road St. Mary's If Undar 1 Yaar Birthplece (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Deys 11MM 2□ F 83 Director April 22, 1917 Maryland 220-05-3274 Usuel Residenca of Decedent the Manyland 10d. Inside City Limits 10e. Steta 10c. City. Town or Location 10b. County e filed within 72 hours after death with the maryimal Hygiene.
I other then "netural", or flema 33a or 28a-f show ivent, the Mexical Examinar must be notified at 1 ☐ Yas 2 ☑ No Director Maryland St. Mary's **Lexington Park** 10a. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21689 Hancock Road 20653 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Dacedant Evar in U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No 1 ☐ Never Merried 2 ☐ Married White 21215-0020 1 Yes 2X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Yaer or Detes: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry State Highway Elementery/Secondary (0-12) College (1-4or 5+) Administration permit. Pages 1 and 2 should be filed to bepartment of Health and Mental Hygie Important: if item 27 is marked other to any injury or other traumatic avent, the once. 5th grade Tractor Driver Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Charles Noda Alexander Combs Agnes Aud 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, Informent's Neme/Reletionship (Type, Print) Margie Marie Combs (Spouse) P.O. Box 494, Great Mills, Maryland 20634 Baltimore, 20e. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stata Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Holy Face Catholic Cemetery 12/28/00 Great Mills, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Fecility Mattingley-Cardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 20650 P.O. Box 270 Incomplications that caused the Ceth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert tailure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final disaesa or condition resulting in deeth) Myocardial Infarction ane hour Examiner Due to (or es e consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest the burial-tran and Due to (or es e consequença ot): attanding physician Box 68760 Dua to (or as a consequenca ot): 88 USB ! 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. O ۵ yd bengis 1 Yes 2 XNo 3 Probably 4 Unknown of Vital Records, þ 8 24b. Were eutopsy tindings availebla prior to completion of cause of deeth? 24a. Wes an eutopsy performed? page 2 should Be Completed peed After this certificate has 1 Yes 2 No t ☐ Yes 2 ☐ No Physician: funeral director. 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menner ot Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Division Attending 1 Neturel 5 Pending investigation al or Attendin s after death. I Director: Aft in by the fu 1 Yes 2 No 2 Accident 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, tarm, street, tactory, offica building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physictan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

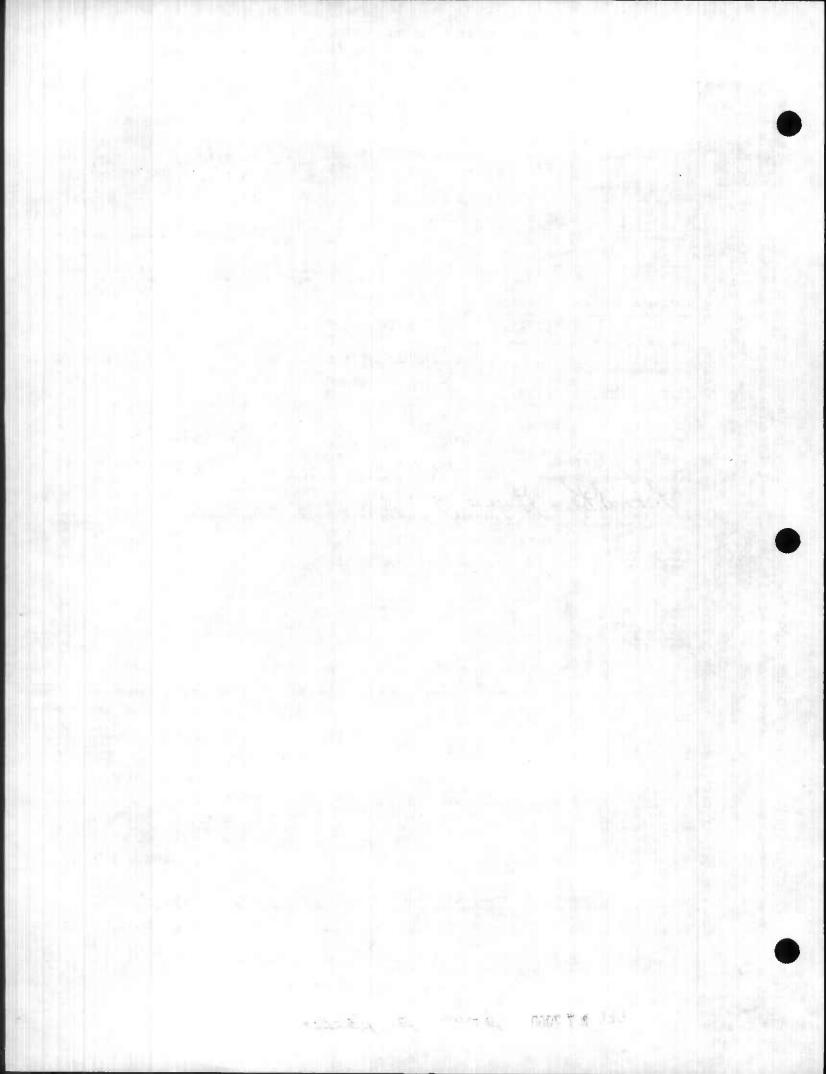
| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and placa, end due to the cause(s) and manner stated. Medical 29e. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M.D. D54346 12/26/00 baby 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Chandra Sajja,
31. Data tiled (Month, Day, Year) Hollywood, Maryland 20636 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 2 7 2000

Begarea



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Vaar BARBARA COLSON DECE 12:50 MBEK 18 200 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death ME JOHNS HOPKINS HOS SALTIMOLE CITY
If Undar 24 Hrs. 8. Data of Birth If Undar 1 6. Sex 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) 5. Social Security Number Days Min. Hours 1□M 2DXF Months 219-48-5174 53 Maryland September 12, 1947 Usual Rasidance of Decedant 10d. Insida City Limits 10c. City, Town or Location 10b County 1 ☐ Yes 2 No St. Mary's Maryland Coltons Point 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 20990 Coltons Point Road 20626 U.S.A. 14. Race - American Indian, 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) Black, Whita, atc. 1 Yes 2 No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 X Married 1 Yas 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12th Nurse Doctors Office 17. Father's Name (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maiden Sumame) Francis DeSales Lawrence Mary Elizabeth Bailey 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Roland Sydnor (Son) 11026 Clinton Avenue, Hagerstown, Maryland 21740 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 XBurial 2 Cramation 3 Ramoval from Stata Charles Memorial Gardens 12/21/00 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Xterdine nechael R3a Part1. Enter the disease, or complication that occased the death, bo not antar the mode of dying, such as cardiac or respiratory arrast, shock, or hear failure. List only one cause on each line. Approximata Intervel Between Onsat and Death Sepsis Immediate Cause (Final disaasa or condition rasulting in death) 24 hours Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uas contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Cervical Cancer 24b. Ware autopsy findings 24a. Was en eutopsy available prior to completion of cause of daeth? 1 Yas 2 No 1 Yas 2 No 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 ☐ Pending

Physician /Medical Examiner requires that the death certificete be execu Box 68760

Physician

/Medical

Examiner

10a State

Funeral

Director

23a or 28a-f show

Herna

8

other

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: if then 27 is marked oth any Injury or other traumatic even ands.

filed within 72 hours after

Maryland 21215-0020

Baltimore,

Division of Vital Records, P.O.

Physician:

or Attending

To the Hospital o within 24 hours af To the Funeral D completely filled i

edical

the Medical Examiner must be notified at

Director

Funeral

by

Completed

Be Completed by Physician/Medical Examiner Certification: To After s after deeth. 3

25. Was casa rafarred to madical axaminar? 1 Yes 2 No 27. Mannar of Daath

1 Natural invastigation 2 Accidant 6 ☐ Could not be 3 ☐ Suicida

4 | Homicida 29a. Certifiar

(Check only

28a. Placa of Injury - At homa, farm, straat, fectory, office building, atc. (Specify)

1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. Licanse number 29d. Data signed (Month, Day, Year)

29b. Signatura and titla of cartifiar J. Min mo PHYSICIAN

RES-000

DECEMBER 18, 2000

30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print)

SHANNON J. WINAKUR, MD; JOHNS HOPKINI HOSPITAL; BALTIMORE, MARYLAND

State Registrar 31. Data filed (Month, Day, Year)

DEC 20 2000

32. Registrar's Signatura

one of the same The same the

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Thomas 12 25 Clark 00 6:04am /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Easton Talbot Memorial Hospital at Easton 7. Age (In yrs. lest birthdey) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠ M 2□ F Yrs. June 16, 1928 Director 72 Pennsylvania 215-26-3854 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Weddell Examinar must be notified at 1 ☐ Yes 2X No Directo Maryland Caroline Denton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 11476 Knife Box Road 21629 United States Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: by 3 Widowed 4 Divorced Year or Dates: Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "nat any injury or other traumatic event, the Medical once. Elamantary/Secondary (0-12) College (1-4or 5+) Farmer/farm manager 11 HS Grad. Beef Cattle 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be Thomas Hazel Clark Margaret Louise Shutt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Lois F. Clark 11476 Knife Box Road, Denton, Maryland 21629 Baltimore, 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/30/00 Denton Cemetery Denton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Fecility
Moore Funeral Home, P.A. vee 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician Immediate Cause (Final disease or condition rasulting in death) /Medical MYOCARDIAL INFARCTION S AS Examiner Dua to (or as a consaquance of): Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Dua to (or as a consaguanca of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? s been signed by the should be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 30 2 page 1 Tyes 2 No this cartificata spital or Attending Physician: Theorems after death.

neral Director: After this carificate filled in by the funeral director, pe 25. Was case referred to medical Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1□ Yes 2 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 27. Manner of Death 28d. Dascribe how injury occurred Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Straat end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C Hospital edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title 29c. License number 0 00 H 41416 30. Nema and address of person who complated cause of death (Item 23a) (Type, Print)

DHMH t6 Rev 6/95

Registrar

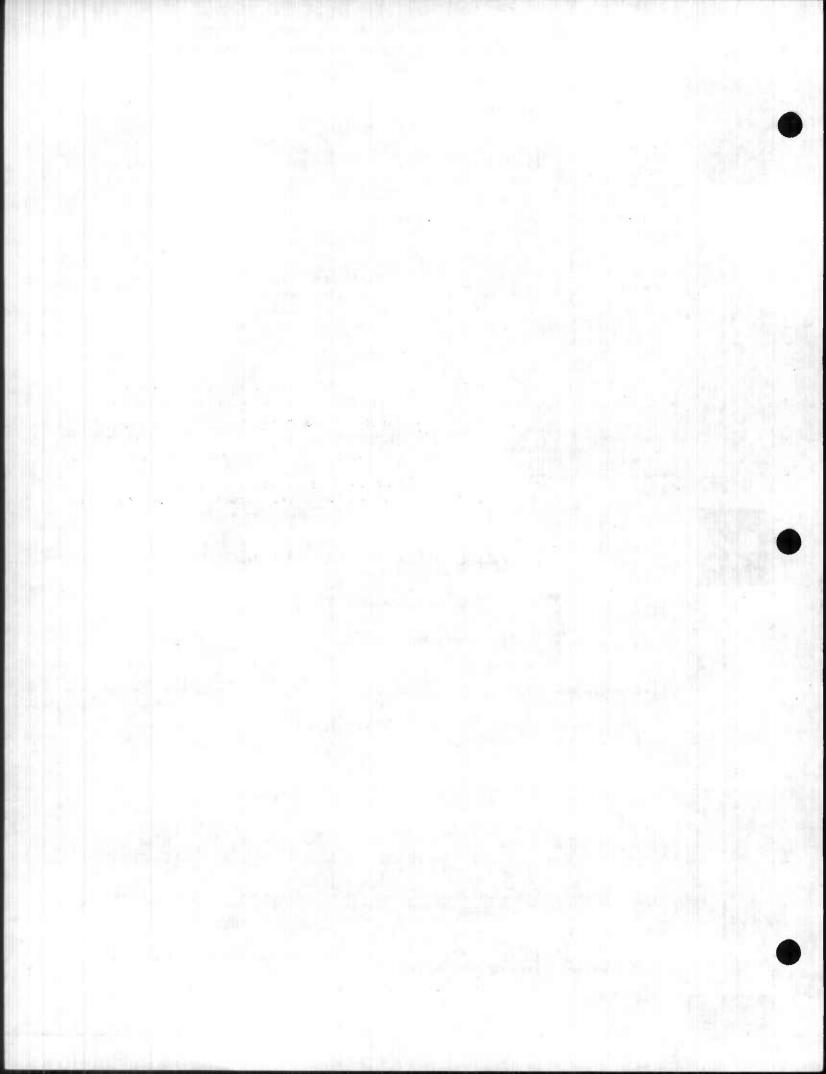
John R. Condit, Jr.,

DEC 2 7 2000

31. Dete filed (Month, Dey, Year)

32. Registrer's Signature

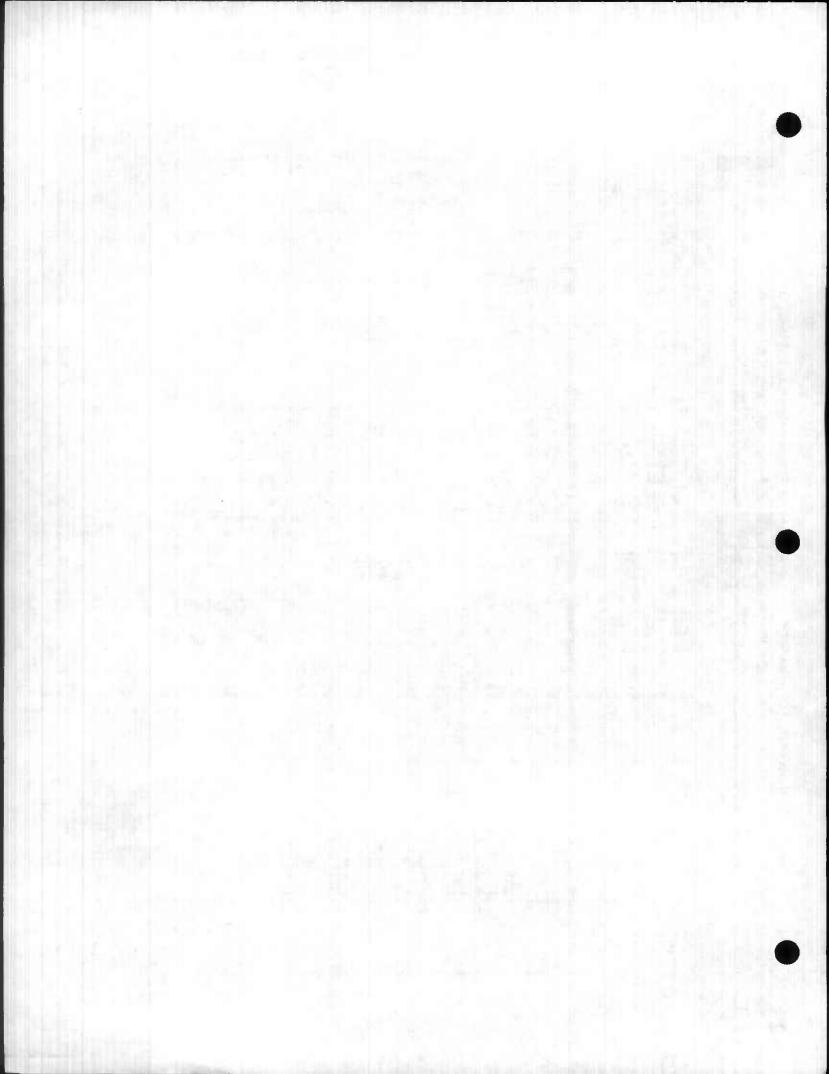
403 Marvel Court, Easton, Maryland 21601



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 42386

Physician / Medical Examiner Funeral Director The build-transit and Information of the property of the prope	Shore Nursi Shore Nursi Shore Nursi Social Security Number 21-20-3945 Sual Residence of Decedent Da. State 10b. County MD Carolir De. Street and Number 10 Colonial Dr De. Street and Number 11 Dr De. Street and Number 12 Merried 3 Widowed 4 Divorced 15 Decedent's E (Specify only highest gr Etementary/Secondary (0-12) 12 The Etementary/Secondary (0-12) 12 The Etementary/Secondary (0-12) 13 Decedent's E (Specify only highest gr Etementary/Secondary (0-12) 12 The Etementary/Secondary (0-12) 13 Decedent's E (Specify only highest gr Etementary/Secondary (0-12) 12 The Etementary/Secondary (0-12) 13 Decedent's E (Specify only highest gr Decedent's E (Specify only highest g	ia Christ ive street and number) ing & Reh Sex 1 M 2 F 7. Age 12. Was Decedent E Amed Forces 1 Yes 2 N If Yes, Give Year or Dates: Education rade completed) 1 College (1-4or 5-1) it) mann (Type, Print) a ughter Print Caused one cause on each line over the street and number)	a b i l i t e (In yrs. last bi 7 6 10c. City, Tov D e n t c Ever in U,S. lo 16a +) F 6 20b. Place comete A r l i r	tatio irthday) If M Yrs. M 13. Was If Ye I I I a. Decedent (Give kind life. DO) I b. Mailing A 3 Lea of Disposition on y cremeton g to n 22. Na 1 5	ion 10f. Zip Code 2 1 6 2 9 s Decedent of es, specify Cut l Yes 2 No 1's Usual Occur d of work done NOT use retire C 0 1 1 e c Address (Stree a the rm n (Name of ony or other pia n Nati	Hispanic Origin? (ban, Mexican, Pue o Specify: upation e during most of weed) 18. Mother's Na Marie at and Number or Hian Dr. ace) onal	Specify Yes or North Rican, etc.) Specify Yes or North Rican, etc.)	Dey 28 th 4c. County Carr th ay, Year) 10g. Citizen of Y USA 14. Rac Specify 16b. Kind of B S tate Parks A maiden Suman Herrma Der, City or Town, G Water 20c. Location Arling	9. Birthplace (State or Fore Country) Germany 10d. Inside City Lim Y Yes 2 What Country? What Country? White, etc. White and Recreation Re						
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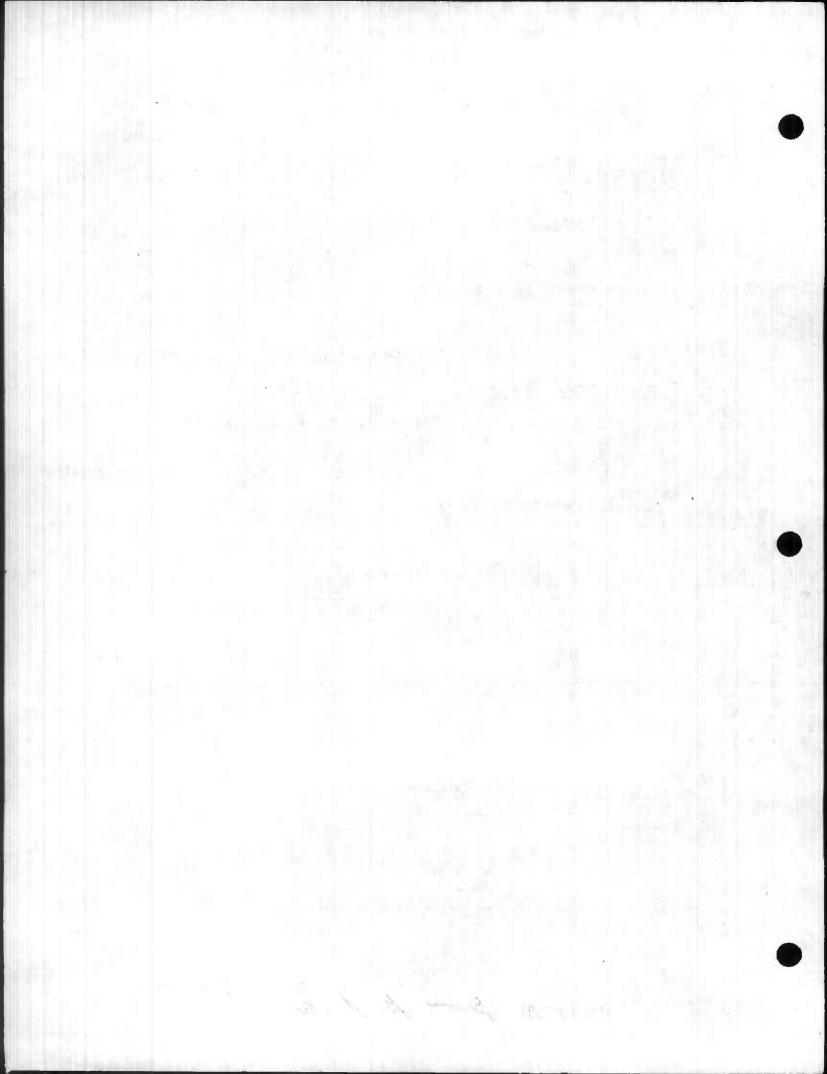


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landa _	Corbin AMEND ITEMS:	#23 PART I,	State of Maryland / 27 PER MEO G791 1-30-01 WR.	Department of Health and Mer Certificate of Death	ntal Hygiene Reg, No.	00	4238

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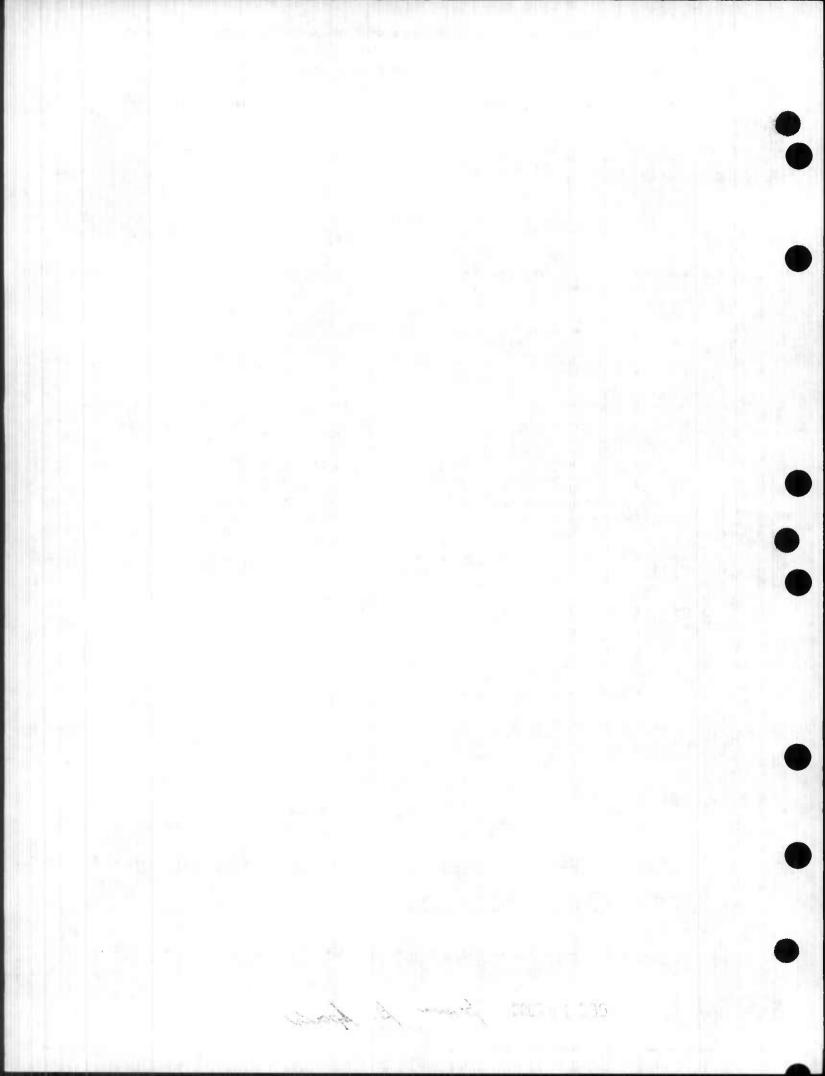
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		State of h	varyland		artment o	of Health of Death				0 46	389
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Physician	EVA TWIGO		R				12		10 20	Year 7:	10 P.M.
/Medical Examiner	4a Facility Name (If not institution					4b. City, To	own, or Location of		4c. County of		io r.m.
Examiner		oint	-			CHES	STERTOWN		KEN	г	
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0	THOMAS R. TWI	LGG				SUI			15. 60	1.57	
	19a. Intormant's Name/Relations			19b. Maili	ng Address (S	treet and Numi	ber or Rural Route	Number,	City or Town,	State, Zip Code)	
	DONALD STOWELL	COOPER					CHESTER	7		1620	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 DRemovel from Stel	Ca	ace of Dispo metery, crea	osition (Name matory or otha	of r place)	Date	20	Oc. Location - (City or Town, St	ata
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gen	S Doith	musel	1				HOMES &				
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ai Examiner			200 10 (01	03 0 00/130/	quonoo ory.						
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Physician/M	ENLINE	d							-		
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ilcai Certification: T	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ 29a. Certifier Check only 2 Medical 1	g Physician: To the best	etc. (Specify st ol my know ol examinati	vledge, deat	h occurred at t	he time, date a	and place, and due	to the cau	use(s) and ma	nnar as stated. and due to the c	
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State Registrar



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State of Maryland / Department of Health and Mental Hygiene 0 0 42390

Certificate of Death

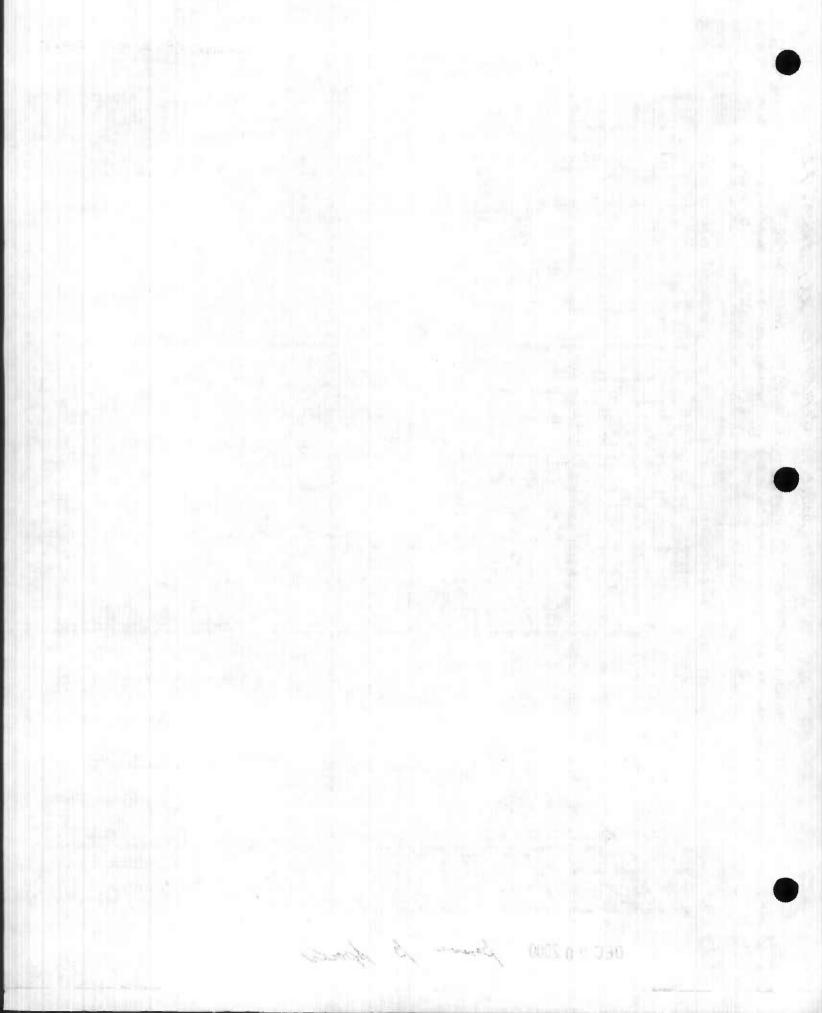
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State of Maryland / Department of Health and Mental Hygiene 0 0 4239 |

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Robert L. Coston, Sr. 0937 2000 16 /Medical 4a Facility Nama (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Days Months Hours 15 M 2□ F 217-30-8113 65 Director Jan 30, 1935 Usual Rasidence of Decedant 10d. Insida City Limits 10a State 10h. County 10c. City, Town or Location 1X Yes 2 □ No MID Worcester Director Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8 o filed within 72 hours after death with al Hygiene. other than "natural", or frems 23a or vent, my moderal Examinar mans to 203 Petitt Street 21863 U.S. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian. 11. Marital Status Black, Whita, atc. 1 X Yes 2 No Army If Yas, Giva Yaar or Datas: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 € Divorced Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12th Auto Mechanic County Government 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) 2 should be f Earl L. Coston Lessie Kelly 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Peges 1 and 2 sh Department of Health and Important: If item 27 is m eny injury or other traum pace. Robin L. Coston/daughter 5531 Princess Way, Snow Hill, MD 21863 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Mt. Wesley Cemetery 12/23/00 Snow Hill, MD 22. Nama and Addrass of Fecility 21. Signatura of Fur aral Service Licensee Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 Approximata Intarval Batween Onset and Death 23a. Party Entar tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Ceusa (Final diseasa or condition resulting in deeth) Examiner edicai Examine Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last physiclan oronar Due to (or as a consequance of): Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No PV 24b. Were eutopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 20 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medicel Be 28. Placa of Deeth (Check only ona) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 No 27. Mennar of Deeth 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: Injury 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 3 Suicide 6 Could not be datarmined 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicida

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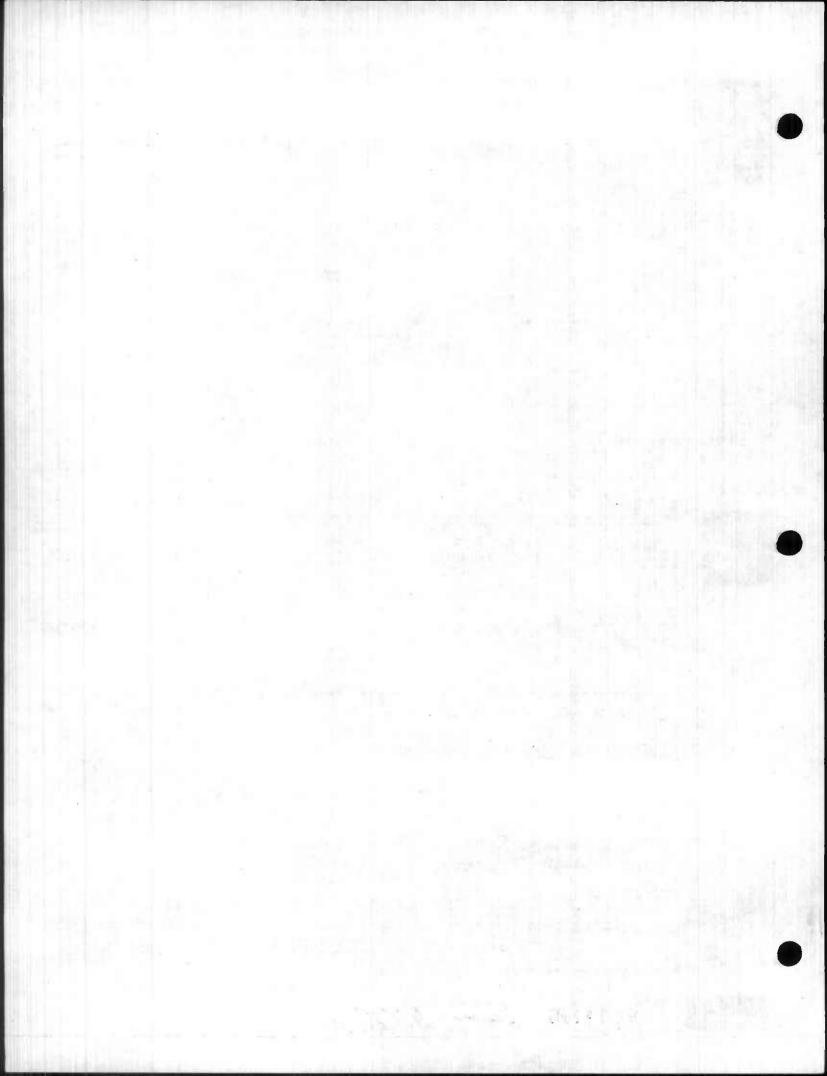
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 12 Vee Physician 205 a.m Eavl Carter 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner altrulle Hearsland Home Health Care & Hospice Prince George's Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Yeer Months Devs 5. Social Security Number 9. Birthplace (Sets or Foreign Country) **Funeral** Deys 110 M 2□ F 578-26-9193 Director 78 01-11-1922 Georgia Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b Counts 7 is marked other than "natural", or Itama 23a or 28a-f ahow traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4703 Sheriff Road, N.E. 20019 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritel Status Bieck, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: Black by 3 Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiena. filed within Elementery/Secondery (0-12) 9th College (1-4or 5+) Plaster Self-Employed 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) 12 should be fine and Mental H Samuel Carter Carilee Fant 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 la m any Injury or other traum pacs. 19e. Informent's Neme/Relationship (Type, Print) Sarah C. Britt 4001 Cooper Lane, #D8; Hyattsville, MD 20784 20b. Place of Disposition (Name of cematery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State Lincoln Memorial Cemetery 12-18-00 Suitland, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signeture of Funeral Service Licenses Bacon Funeral Home, Inc. Wanda C. Bacqu CCO 34/ 3447 14th Street, N.W. Wash: 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 3447 14th Street, N.W. Washington, DC 20010 Approximate Intervei Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) moscleratic cardio variable diserse Examiner Due to (or es e consequence of) Examiner arelita the death certificate be executed physician and s the buriel-trens Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as e consequence of) Hyperson Due to (or es e conse Physician/Medicai Due to (or es e consequence of): US0 88 the attending jo Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by Corelino variolor accident þ 8 24b. Were eutopsy findings available prior to completion of cause of deeth? should ! 24a. Wes en autopsy performed? Completed hent Jailine The lew page 2 After this certificate has 1 Yes 20 No 1 Yes 2 No of Vital To the Hospital or Attending responsibilities a hours after death.

To the Funeral Director: After this certifice to the Funeral Director. 25. Wes cese referred to medicel examiner? Be 26. Piace of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes ≥ No Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier physicion DOO 56420 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kefer Wagner 4203 Queensbury Rel, Hyntsnike, 31. Dete filed (Month, Day, Year) 22 Registrar's Signature State DEC 1 8 2000 Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Daia of Death 3. Tima of Death Month Dec. 18 2000 William Colbert 9:00 AM 4a Facility Nama (if not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Crescent Cities Prince Georges Center Riverdale If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Days Months 1 M 2 F 83 084-05-6173 May 8 1917 New York Usual Rasidance of Decedant 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yas 2 ☐ No Maryland Prince Georges Seabrook 10f. Zip Code 10c. Citizen of What Country? 10e. Street and Number U.S.A. 6902 100th, Ave. 20706 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Nexican, Puerto Rican, atc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 (☑ Yes 2 ☐ No WW ☐ I If Yas, Giva Year or Dates: 1 Nevar Marriad 28 Married White 1 Yes 2₺ No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elamentary/Secondery (0-12) College (1-4or 5+) U.S. Army 17. Fathar's Nama (First, Middla, Last) Administrator 18. Mother's Nama (First, Middle, Maiden Surnama) William J. Colbert. Cecilia McCormick 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Ruth E. Colbert (Wife) 6902 100th. Ave. Seabrook, MD 20706 20b. Place of Disposition (Nama of carnetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 12/18/00 Alexandria, VA 21. Signature of uneral Seprice License 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD. 20706 esse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, me. List gary one cause on each line. Approximata Intarvel Between Onset and Death week neumonla Immediata Causa (Final disaasa or condition rasulting in deeth) Due to (or as a consequence of): Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disaase or Injury that initialed avants rasulting in death) Las! Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? woolung 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Mmonory Depleaulon 24b. Ware autopsy tindings available prior to 24a. Was an eutopsy completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

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"naturel", or

Pages 1 and 2 should be filed within 72 hou nant of Haalth and Mental Hygiane.
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permit. Pages 1 and Department of Haalth Important: if Item 27 eny Injury or other tr once.

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21215-0020

Baltimore, Maryland

Box 68760,

P.O.

Records.

Division of Vital

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Certification: To or Attending in 24 hours after death.
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Registrar

25. Was casa refarred to medical 1 Yas 2 No 27. Manner of Death

1 Neturel

2 ☐ Accident

3 ☐ Sulcida

29a. Cartifiar

4 Homicide

(Check only one)

5 Panding invastigation

6 Could not be detarmined

28a. Data of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner stated.

29b. Signatura and titla of certified York - would

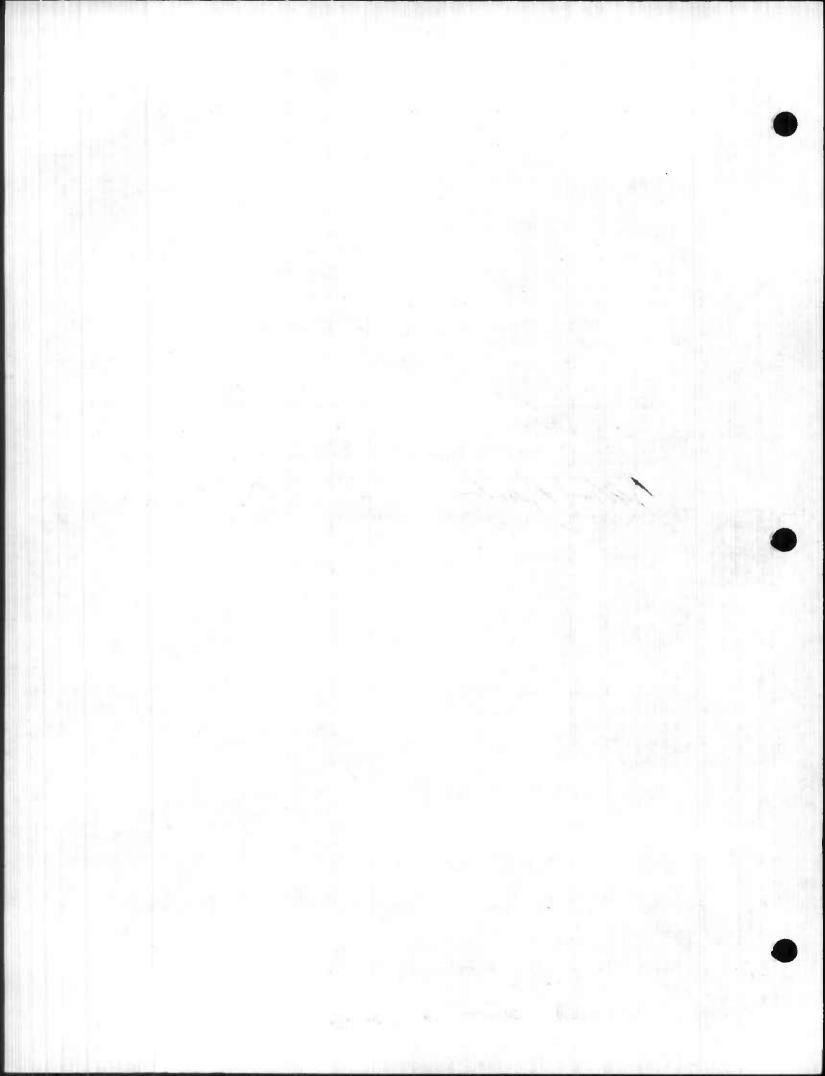
29c, License number 025079 29d. Date signed (Month, Day, Year)

20704

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

Don H. Loblonowitz, MO 7401 Executive Place, #002 Salvook
2070

31. Data filed (Month, Day, Year) DEC 19 2000 32. Registrar's Signature

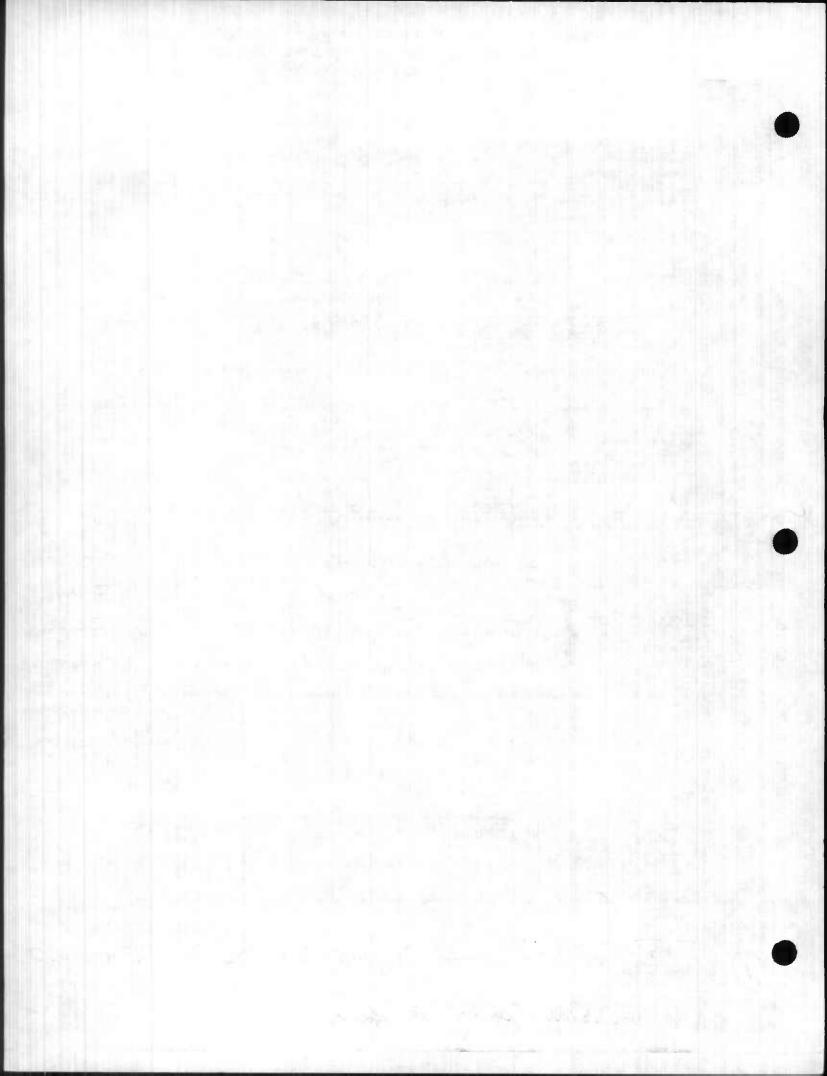


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2396

				Ce	rtificate of	Death	F	Reg. No.			
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Viital		25. Was case referred to medical					ath (Check only o	ne)			
o to	E 00 TO	1 TYPE 2 NO	Hospital: Inpatient 2	☐ ER/Outpatie	ont 3□ DOA Ot	her: 4 Nursing I	lome 5 ☐ Resid	denca 6 □Ott	ner (Specif	(y)	
0	tending Phy deeth. for: After this the funeral		28a. Date of Injury (Month, Day Year)	28b. Time of	of 28c. Inju	iry at	28d. Describe t	now injury occur	red		
Division	offin	1∠Natural 5 Pending 2 Accident investigation									
Nis.	tal or Attanding P rs after deeth. al Director: After I ed in by the funer.	3 Suicide 6 Could not be determined	288. Place of Injury - A				ber or Run	al Route Number,	_		
á	after Direction of the	4 Homicide	building, etc. (Spe	city)			City or Tov	vn, Stete)			
	ours fille		rsician: To the best of my k	nowledge deat	th occurred at the ti	ime, data and place	a, and due to the	cause(s) and m	anner as s	stated.	-
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	(Check only 2 Medical Exami	iner: On the basis of exami and manner stated.	nation and/or in	vestigation, in my	opinion, death occi	urred et the time,	date and place,	and due to	o the cause(s)	
	the mple		and mainer stated.		29c. Licen	se number		29d. Date signe	ed (Month	Day, Year)	-
	- N - O	255. Signeture and three of Certiner	/	n	250. 20011	- Tumber			a (mom),		
	0	D7/1		41)	mD3	31983 -	-DC J	keemb	er 1	4,2000	
	(1)	30. Name and address of person who c	ompleted cause of deeth (I	tem 23e) (Typa,							
		BOYD HEHN		900	O ROCKVII	LE PIKE,	BETHESD	A, MARY	LAND	20892	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	neture /	1						
	D 2 - 4		Charles	23	MAR. W.	1					

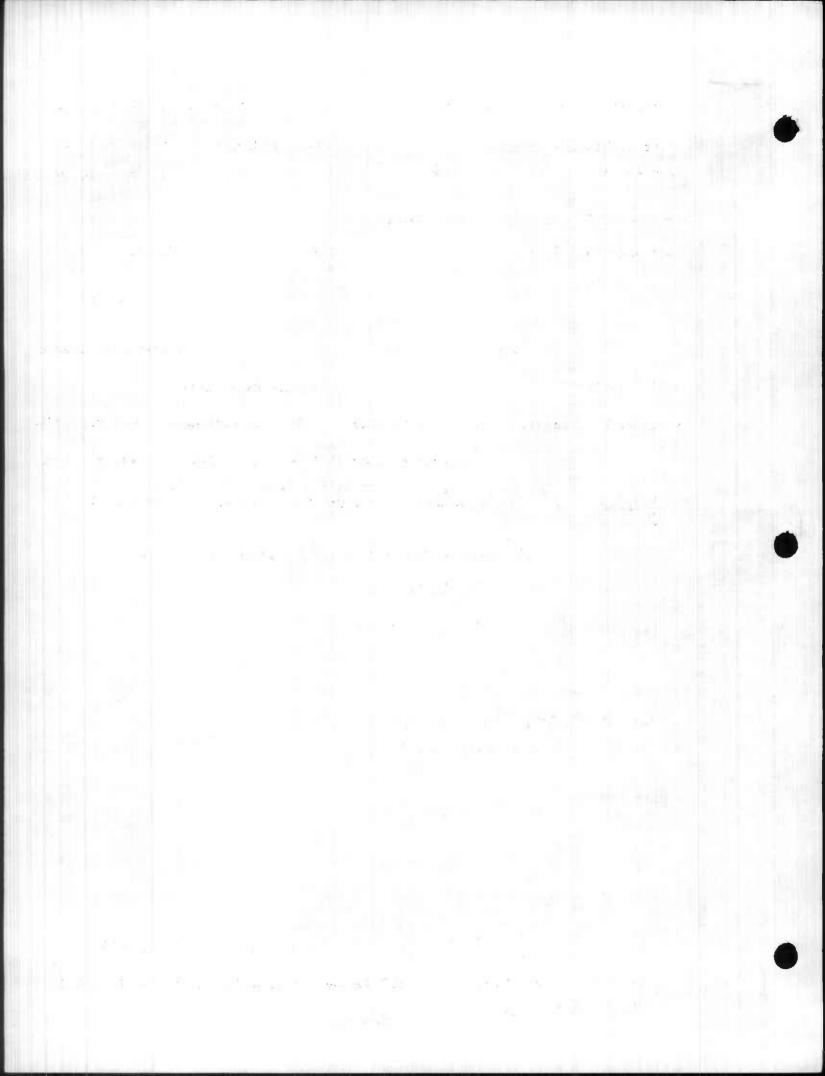
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 1, 2397

				Cert	ificate d	of Deat	h		Reg. No.		
	1. Decedent's Name (First, Middl	e, Last)						2. Data of Dea		Vaar	3. Time of Deeth
Physicia:	MURREN. III	UIS CRA	GHEAD					Decembe	r 12, 2	000	2:15 AM
/Medica Examine	A - F - 10th . bl 4M A i - Air . Air .	, give street end numb	er)			4b. City,	Town, or Lo	ocation of Death	4c. County	of Deeth	
	Fort Washingto	n Hoenital				Fort	Wash	ington	Princ	e Geo	orges
Funeral	5. Sociel Security Number	6. Sex 7.	Age (in yrs. last b	oirthday)	If Under 1 Y	ear II Und		8. Date of Birt (Month, De	h		elece (State or Foreign
Director	227-34-3917	1₩ 2□ F	68	Yrs.	MOTHETS	ays Hours	IVIVII.				oke, Virgi
P .	Usuel Residence of Decedent		140 CV T								
anyla:	10e. Stete 10b. County		10c. City, To								Od. Insida City Limits
Ba-f	Maryland Prince	Georges	Fort W	lashi	ngton						1 TYes 2 □ No
within 72 hours after death with the Maryland ena. than "natural", or items 23a or 28a-f ehow he Med sel Examiner must be northed at	Maryland Prince	"			10f. Zip Co				10g. Citizen of V		itry?
23a		#234				20744			U.S.A		
r de	11. Marital Status 1 Navar Marriad 2 Man	12. Wes Decede Armed Force	es?	13. W	as Decedent Yes, specify (of Hispanic (Cuban, Mexic	origin? (Sp an, Puerto	ecify Yas or No Rican, etc.)	14. Rac Bled	e - Americ ck, White,	en Indien, etc.
or h		ed 1 7 Yas 2 If Xes, Giva	□No	1[□Yes 2X	No Specia	y:		Specify	Bla	o.le
"natural", or	3 □ Widowed 4 □ Divorced	Year or Data	is:								
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within ena. than	Elementery/Secondary (0-12)	College (1-4	or 5+)	Mini:	ONOT use re	etirea)			Prochyt	eria	n Church
ould be filed within Mental Hygiena. arked other than aftic event, the Mentice of the Mentice o				PILITE	3001	18 Mol	har's Nam	e (First Middle	Meiden Sumer		. Onarch
should be filed and Mental Hygi marked other imatic event, I	n John C Conscho									10)	
should ind Men in merke umetic	2							earl Ha			
2 2 2 2	19a, Informent's Name/Relations								er, City or Town,		
is 1 and 2 if Haalth Itam 27 i	Florence K. Cra	ighead - Wi					, Ft.	. Washir	1gton, M		and 20744
5 5 5	20a. Method of Disposition 1 Burlal 2 □ Cremetion	3 Removal from Sta	cemer	ery, creme	ition (Neme of story or other	pleca)	1	Date	20G. LOCATION -	City of To	WII, Stele
man man tant: lury	4 Donetion 5 Other (S	pecify)	Harmo	ny M	emoria	1 Park		12/18/00	Landov	er, l	Maryland
permit. Pages Department of Important: If i any injury or page.	21. Signatura of Funeral Service	Licensea		22.	Name end A Marcha	ddress of Fed	ility 'unera	al Home	Inc.		
205 8 3	Julia	P. M	Ershall	0					shingto	n DC	20011
	23e. Part. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. Do							1	Approximate Intervel Between
Physician	Status of South Females. Loss	511y 5110 54055 GT 400									Onset end Death
/Medical	Immediate Cause (Final disaasa or condition	Alho	ero sclo	long	ue c	addi	ova	ncular	dison	10	
Examiner	resulting in deeth)	0. / 1 / / (01	D V	, 0 4 (4)	CITTA		
	Due to (or es e consequence of): Diabetes mellitus										
cuted	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying	b	Due to (or es a			, - ,					
			H400	Ten	6.00						
ite be	Cause (Diseese or Injury that initiated events resulting in deeth) Lest	c	Due to (or es e								
as th	E lessuring in deetin, cest									- 1	
sath certifice attending pl		d								1	
0 0 7	Pert II. Other significant condition	ns contributing to deat	h but not resulting	in the und	derlying caus	e given In Pe	rt I.	23b. Dld	lobecco use co	ntribute to	the ceuse of seeth?
law requiras that the di as been signed by the 2 should be detached	Pert II. Other significant condition	2 77	0	, , \	1.	C		1 🗆	Yes 2□ No	3 Pro	bably 42 Unknow
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quira an sig			0	0 -		1 2 1		24a. Wes	en eutopsy		ere eutopsy findings ellable prior to
sw requisite sections is been 2 should	al) ease	Chron	ric Ren	al li	nsur	Ti Cure	A-	pone	illiog :	CO	mpletion of ceuse deeth?
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certificate rector, pag						26 DIs	on of Dogs	th (Check only o		1	3.00
Physician: this certificanal director,	25. Was cese referred to medica examiner? 1 Yes 2 X No	Hospital:	eatient 2 ZER/C	Outnotiont	3□ DOA	Other			dence 6 □Oth	er (Snecil	641
Phys ratio		28e. Dete of I	Injury 28b.	. Time of		Injury at Work?	Nuising ne		how injury occur		<i>y)</i>
i or Attanding Ph after death. Director: After th d in by the funeral	Naturel 5 ☐ Pendir	8	Dey Year)	Injury	м	Work? 1 ☐ Yes 2	□No				
or Attanding Parier death. Director: After the funers of in by the funers	3 Suicide 6 Could	ot be	Injury - At home.	ferm, stree	et, fectory, of	fice		28f. Location (Street end Numb	per or Rure	el Route Number,
after Dire	4 Homicide	building,	Injury - At home, , etc. (Specify)		.,,			City or To	vn, Stete)		
ours erai filled		g Physicien: To the be	ast of my knowledg	ne deeth o	occurred et th	ne time date	end plece	end due to the	ceuse(s) and me	anner es s	teted
To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b		Examiner: On the basis	s of examinetion e								
ithin of the complete of the c	29b. Signature and title of certifie				29c. Li	cense numbe	r		29d. Date signe	d (Month,	Dey, Year)
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10/	30. Neme end eddress of person										20052
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DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 8 **Physician** 2000 Ceaser James Cheek December 11:25 a.m /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner 2266 Brightseat Road, #101 Landover Prince George's If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 25, 1951 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Deys Months 1 M 2□ F Wash., D.C. 49 Yrs 579-64-7700 Director Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at 1 Yas 2 No Directo Maryland Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? deeth with 2266 Brightseat Rd., #101 20785 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, etc. should be filed within 72 hours after and Mental Hygiene.
marked other than "natural", or itse 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give X 1 ☐ Yas 2 No Specify: Specify: by 3 Widowed 4 Divorced **Black** Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Second ondery (0-12) College (1-4or 5+) Supervisor Transportation permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If fam 27 is marked othe and intury or other traumatic avant 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be Clifford Cheek Margaret Pitts 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Marion Burrows - Sister 5223 Daventry Terr., Forestville, MD 20b. Plece of Disposition (Nema of cematary, cremetory or othar pleca) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 12/23/2000 Landover, MD Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Licenses Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, or hear failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical Severe Cardio Vascular Disease Examine Due to (or es e consequence of): Examiner Congestive Heart Failure physicien and the burial-transit The law requires that the death certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of) for use as 82 signed by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by been sig 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No certificate 1 □ Yas 2 □ No Division of Vital Attanding Physician: 25. Wes case referred to medical examiner? director Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Netural 2 ☐ Accident 5 Pending efter death.

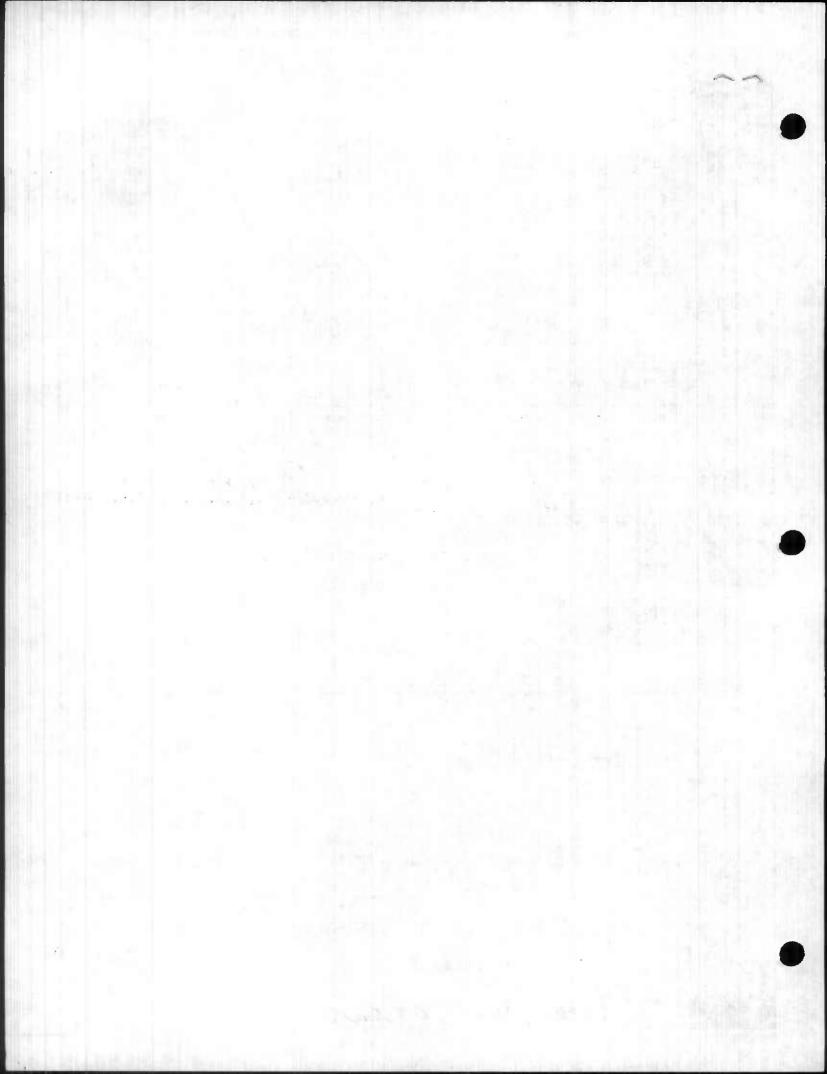
Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigetion 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Dirac completely filled in b. 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, daath occurred et the time, date end plece, and due to the ceuse(s) and menner steted. edical 29e. Certifier (Check only 29b. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) D0009451 December 21, 2000 30. Neme and address of pereon who complated causa of death (Item 23e) (Type, Print) Benjamin S. Pecson, MD 6106 Silver Hill Rd., Forestville, MD 20747 31. Dete filed (Month, Day, Year)
DEC 2 2 2000 32. Registrer's Signeture State

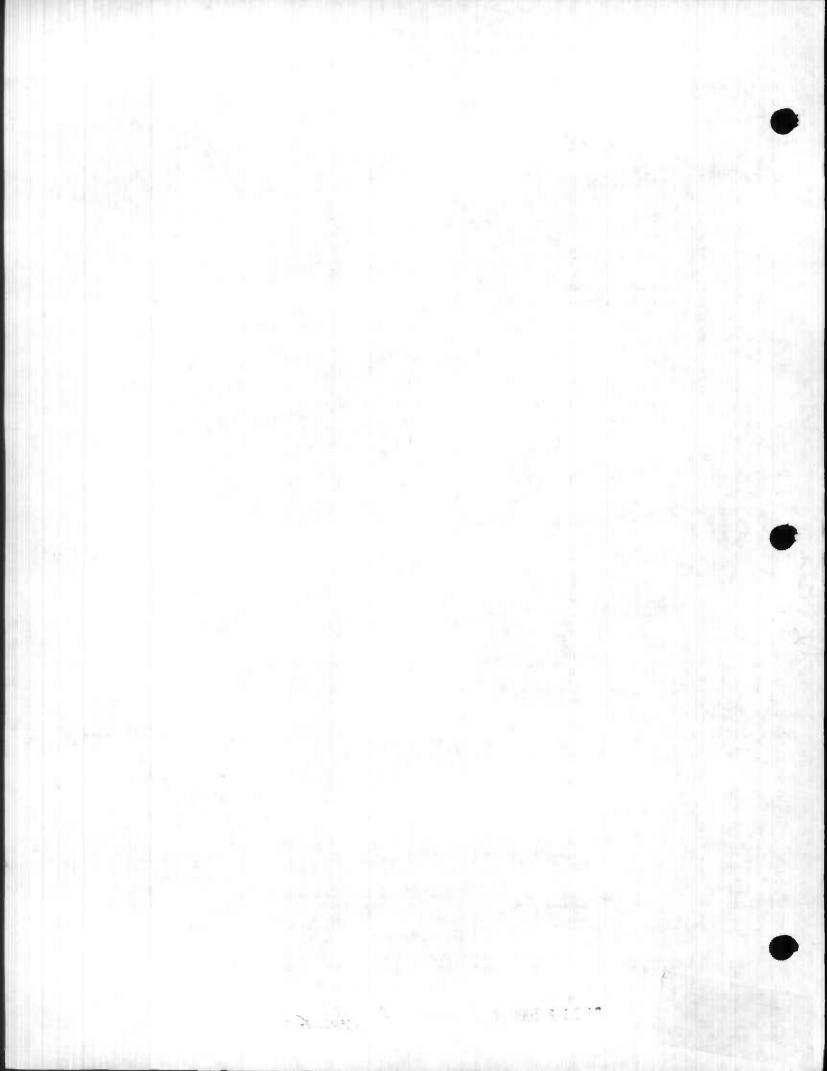
DHMH 16 Rev 6/95

Registrar

ORIGINAL



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Physician	ELIZABETH	ELEANOR CO					De	Dete of Dee Month ecembe:	Dey r 9, 20		3. Time of Death
Examiner	4e Facility Neme (If not institution, SACRED HEA						own, or Local ERLAND	tion of Deeth	4c. County	of Deeth	ANY
Funeral Director	5. Social Security Number 268–52–3388	3. Sex 1 ☐ M 2 🖾 F	Age (In yrs. lasi	t birthday) Yrs.	If Under 1 Yee Months Dey		Min.	Date of Birth (Month, Dey)CT 27,	Year) 1930	9. Birthpi Coun	lace (State or Foreign try) MD
pu .	Usuel Residence of Decedenf 10a. Stete 10b. County		10c. City, T	Town or Lo	cation					11	Od. Inside City Limits
death with the Maryland ms 23a or 28a-f show Install to notified at	The state of the s	ERAL		ELK GA							1 ☐ Yes 2 No
or 2	10e. Streef and Number				10f. Zip Code			1	Og. Citizen of	Whet Coun	try?
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urs after al', or he Examina by Fur	3 □ Widowed 4 □ Divorced	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Dete	S? No		Ves Decedent of Yes, specify Cu ☐ Yes 2 No			an, etc.)	Specif	ck, White, o	
72 ho	15. Decedent's	Education and a completed	1	6e. Deced	ent's Usuel Occ	upetion	t of working		16b. Kind of B	usiness/Ind	lustry
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nd 2 Iff ar 27 is 27 is	19a. Informent's Neme/Reletionship DONALD E. COPEL		AND	Rt.	g Address (Stre L, Box 7						Code)
4 H & B	20e. Method of Disposition 1 🛱 Burial 2 Cremefion 3 4 Donetion 5 Other (Spe		cem	etery, cren	sition (Neme of netory or other p METERY	ece)		2/00	20c. Location -		
permit. Pages 1 ar Department of Hea Important: If then any injury or other price.	21. Signature of Funeral Service Li	censee)	ock	- 1	Neme end Add DAVID A. 710 CHUR	BURDO	OCK FU			л 2°	1538
	23a. Part1. Enfer the diseese, or co shock, or heert failure. List or	omplications thet cause	sed the death. I							1D Z.	Approximete Intervel Between
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)	9	Respire Due to (or es		y Fa.	اسع				1	42 days
certificate be executed use as the burishtransit	Ceuse (Disease or Injury that Initiated events resulting in death) Lest	c	Due to (or es								
o death he atter ed for a		contributing to deat	h but not resultin	ng In fhe ur	nderlying cause (jiven in Pert	I	23b. Did to	obacco uae co	entribute to	the cause of death?
that the design of the design	Se,200	e						1 🗆 Y	ree 2□ No	3 Prot	ably 4 Unknow
been a should eted	Sepri.							24a. Wes e		evi	ere autopsy findings eilable prior to mpletion of cause death?
The law page 2	went	dapand	- 1+					1 🗆 Y	es 200 No	15	Yes 2 No
ertificate sotor, pa Be Co	25. Wes case referred to medical	- PARC	2701			26. Plece	e of Death (Check only or	ne)		
Physici this can al dead	exeminer?	Hospitel:	atient 2 ER	VOutpatien	1 3□ DOA	ther: 4 N	ursing Home	5 ☐ Resid	ence 6 Oth	ner (Specify	y)
Attending Ph or death, sctor: Ahar th by the tuneral		fion	Injury 28 Day Year)	Bb. Time of Injury	28c. In W	uryal ork? ⊒Yes 2□		d. Describe h	ow injury occur	rred	
at or Atta s after data if Directo ad in by if	3 Suicide 6 Could no 4 Homicide determin	ed Zoe. Piece of	Injury - At home etc. (Specify)	e, ferm, str	et, fectory, offic	9	28	Location (S City or Tow	treet end Num n, State)	ber or Aura	l Route Number,
To the Hospital or Attending P within 24 hours after death, to the Funeral Director. After to completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 122 Certifying 2 Medical Ex	Phyelcian: To the be taminer: On the basis and manner	s of examinetion	dge, deeth end/or inv	occurred et the estigation, in my	time, date er opinion, des	nd plece, end eth occurred	d due to the c et the time, d	euse(s) end m late end place,	enner es st end due fo	eted. the ceuse(s)
To the Total Company of the Parket Name of the Park	29b. Signefure end fittle of certifier	Polm - C	onary Ri	nd .	29c. Lice	nse number	err		29d. Date signe		
	30. Neme and address of person wi	no completed cause of	of deeth (Item 23	Be) (Type, I	Print)	4	4 (1)		Decembe	1 11 2	2000
State	Stanky Joseph 31. Date filed (Month, Day, Year)	Mes yal	istrar's Signeture	9	sacred	than's	1 (40)	P. Tel	Cunh	rland	1 MO 21102
Registrar	DEC 1	2 2000	Genera		6 /						9-11



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 📗 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death DEC **Physician** 21°, 2000 CHARLES WILLIAM CAPERONES 6:00 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** Beltsville Prince Georges 4643 Quimby Avenue If Under 24 Hrs. If Under 1 Yeer 8. Date of Birth (Month, Dey Year) Sept. 8, 1944 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Months Deys Washington, D.C. Hours 110 M 2□ F 56 Yrs. Director 579-56-8720 Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f ahow Experience must be notified at 1 ☐ Yes 2√ No Directo Maryland Prince Georges **Beltsville** 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 4643 Quimby Avenue 20705 United States death Funer Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Meritel Stetus Bleck, White, etc. d 2 should be filed within 72 hours after of the and Mental Hygiene.
7 Is marked other than "natural", or Her traumatic avant, us Medical 1 Never Merried 2 Merried 1 ☐ Yes 2 X No Specify: White Specify: P 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupetion 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Printer Washington Post 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) .. Pages 1 and 2 should be fil timent of Haelth end Mental H tart: If Item 27 is marked off jury or other traumatic avar Evelyn Caperones Andrew George Carter 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Hilda Maria Caperones - wife same as #10 Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete permit. Pages Depertment of Important: If It, any Injury or or price. Buriel 2 Cremetion 3 Removel from State Gate of Heaven Cemetery 12/23/00 Silver Spring, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funerel Service Licenses Matthew Brown 5 4400 Powder Mill Rd. Beltsville, Maryland 20705 23e. Pertf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Sudden Respiratory Insufficiency **Examiner** Due to (or es a consequence of) Physician/Medical Examiner Lung Cancer attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequenca of): Diabetes Mellitus that initieted events resulting in death) Last Due to (or es e consequenca of): signed by the a Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy Completed peed performed page 2 1 Yes 2 No 1 □ Yes 2 □ No this certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Deeth (Check only one) examiner? Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this funeral 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 Naturel deeth. 1 Yes 2 No 2 Accident investigetion Diractor: A 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29a. Certifier edical (Check only 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 10 hemeling December 22, 2000 D - 40804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kewal K. Sharma, M.D. 10620 Georgia Avenue, #114 Silver Spring, Maryland 20902

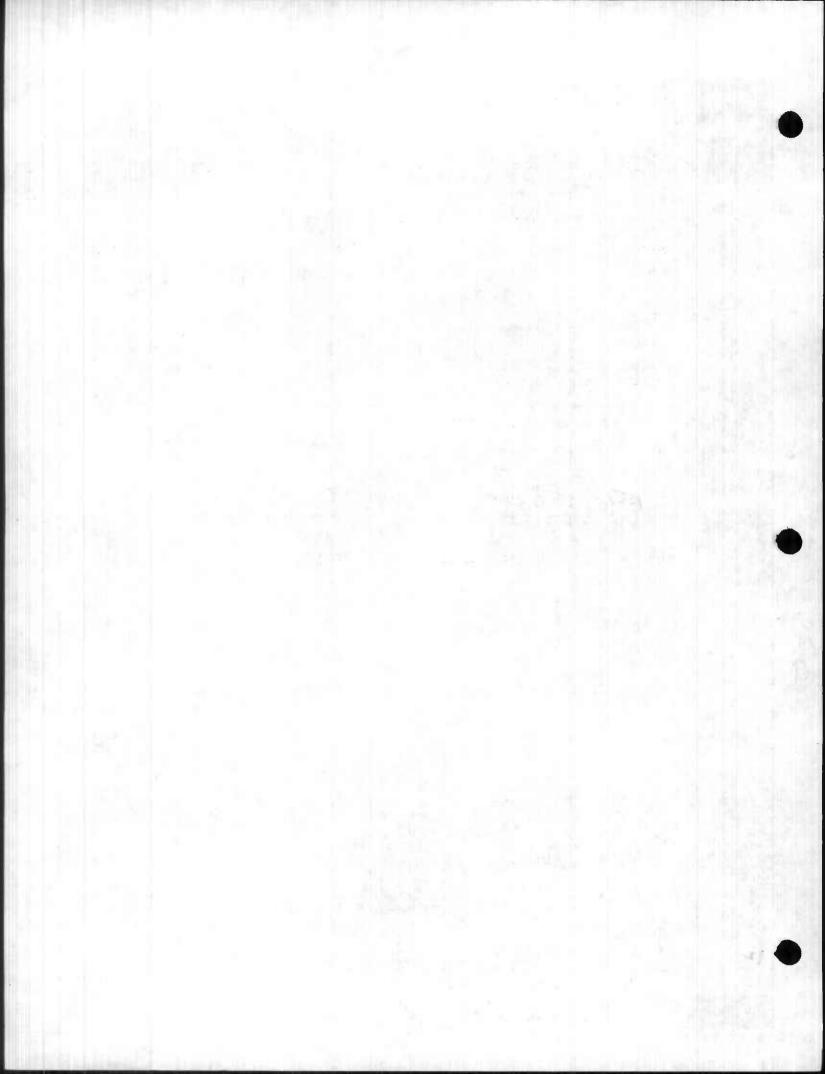
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31. Dete filed (Month, Day, Year)

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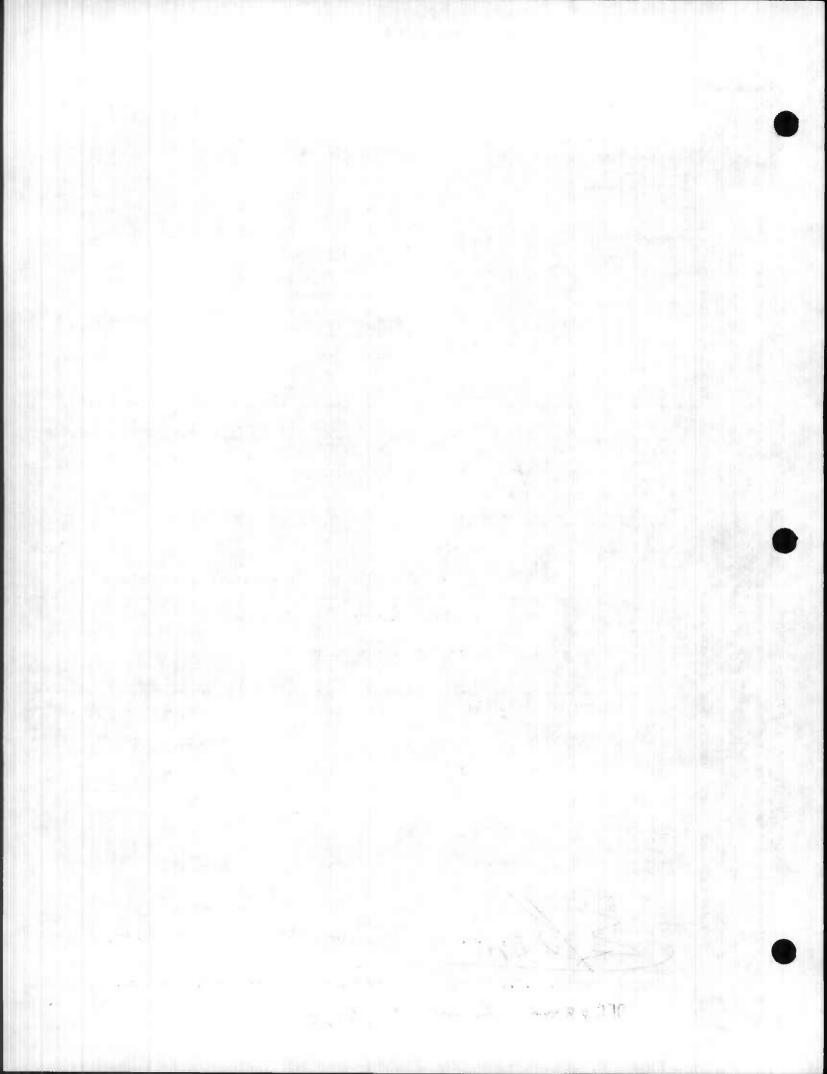
ORIGINAL

32. Degistrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 2402 State of Maryland / Department of Health and Mental Hygiene

			(Certificate of	Death	Re	g. No.		
16.63	1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Dey	Year	3. Time of Deeth
Physician /Medical	14/1 1 1 0m	Stanley		Donalds	on	Decembe			11:20 AM
Examiner	A. F. March Blance Mr. and Jacob Alexander	ive street and number)			4b. City, Town, or	Location of Deeth	4c. County	of Death	
	St. Mary's Nurs	ing Center			Leonardt			. Mar	y's
Funeral Director	5. Social Security Number 6. 705-05-2857	Sex 7. Age (In yrs 101		nday) If Under 1 Yaar Months Deys	If Undar 24 Hrs Hours Min				lece (Stete or Foreign try) Maryland
	Usuel Residence of Decedent					pecoper	12, 10		naryrand
ylan how	10a. Stata 10b. County	10c. C	ity, Town	or Location				11	0d. Insida City Limits
o Ma	Maryland St.	Mary's	Aver	nue					1□Yas 2및No
ter death with the Marylan fer death with the Marylan fer mast be notified at the mast be notified at Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizan of V	Vhet Coun	itry?
23a 23a	39175 Cobrums W	narf Road		2060	9		U	SA	
francesthy references	11. Marital Stetus	12. Wes Decedent Evar in L Armed Forcas?	J,S.	13. Was Decedent of H If Yas, specify Cub	lispanic Origin? (S	Specify Yas or No- to Rican, etc.)		e - Americ	
by l	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Detas:		1□ Yes 2√2 No	Specify:			pecify: White	
ed within 72 hours at ygiene. "netural", or it, me weddes Even Completed by	15. Decedent's		160. [Decedent's Usual Occup	pation	dking 1	6b. Kind of Bu	isiness/Inc	dustry
within 7	(Specify only highest g	College (1-4or 5+)		(Give kind of work done life. DO NOT use retire	d) most of we	икизд			
204	8th Grade		Din	ector of F	inance		County	Gove	rnment
# 1 8 0					18. Mother's Ne	ma (First, Middle, M	aiden Sumem	a)	
should by and Menta marked armatic events.		Donaldson			Annie		Tay	lor	
2 sho and is ma	19e. Informent's Name/Relationship	(Type, Print)	19b.	Meiling Address (Street	end Number or R	turel Route Number,	City or Town,	State, Zip	Code)
127 T	William S. Donal				Wharf H	Raod, Aver	ue, Ma	rylar	nd 20609
10 01	20a. Method of Disposition	CD 14 01.41	cemetery	Disposition (Neme of r, cremetory or other ple			Oc. Location -		
bermit. Peges 1 a Department of Has Moortant: If them iny Injury or othe ance.	1 Burial 2 □ Cremetion 3 4 □ Donation 5 □ Other (Spec		rist	Episcopal(Cemetery?	2/27/2000	Chapti	co, l	Maryland
permit. Peges Department of Important: If I any Injury or pace.	21. Sanatura of Funeral Service Lice	mage	7 15	BY Name Trient	ss of Facility a	Home. P.	Α.		
Ped in a	Edward N. Brin	sfield, Jr. MOO	0052	P.O. Box 2				nd 20	0650
	23a. Part1. Enter the disease, or co								Approximate
Dhysisian	shock, or heart failure. List on	y one cause on each line.							Onset and Death
Physician /Medical	Immediate Cause (Final	Sepsi	S						Lmmediate
Examiner	disease or condition resulting in death)	a					2745	1	
i i		Pleur Pleur	al e	onsequence of):	eft/chron	nic) with p	neumon	ia	
executed n and iel-transit		l b.						1	
n and iel-tra	Sequentially list conditions, if eny, leeding to immediate	Cardi	ac/F	onsequence of): ulmonary Ir	sufficie	ency			
iceta be executed physician and is the buriel-transit edical Examir		C. Due to /	07.95.9.01	onsequence of):					
og physicia es the bu	resulting in death) Last	Corc	nary	Atheroscle	erosis				
attending for use		d							
at the deeth certing by the attending attached for use attached for use Physician/M	Pert II. Other significant conditions	contribution to double but not so	auttina in	the underlying seven si	on in Dort I	22h Did tol	2000 1100 001	ntelbute to	the cause of death
that the de by the detached	Fracture o	f Right Hip	suiting in	the underlying causa gir	ven in Pert I.		s ZO No		bably 4 Unknow
as that igned be date by Pl							8 26.1140	3 - 100	bably 4 onkilot
The law requires that the death certificete be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit completed by Physician/Medical Examil	Hypertens	ion				24a, Was en	eutopsy	24b. W	ere eutopsy findings
The law requiras the law secure signer, page 2 should be Completed by						perform	ad?	CO	ailabla prior to mpletion of cause
has has	Renal Fai	lure/Chronic					35		death?
						1 □ Ye	s 2 No	1	Yes 2□ No
s cartification director	25. Wes case referred to medicat examiner?	Hospitel:		Ott	or:	eth (Check only one			
his ai di		1 Inpatient 2L	ER/Out	petient 3LI DOA	4 Liveursing	Home 5 Reside			(y)
tal or Attending Physician: rs after death. al Director: After this cardifold in by the funeral director, Certification: To Be (27. Menner of Death 1 Naturet 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Ti	jury Wo		28d. Describe ho	w injury occur	Del.	
daeth daeth ctor: A y tha f	2 Accident investigeti	h-			Yes 2 □ No	ON Leasting (Ct.	and and them b	and a Diver	I Poute Mumber
or Attending later deeth. Director: After d in by the fune	4 ☐ Homicide determine	28e. Plece of Injury - At the building, etc. (Special	ify)	m, street, factory, office		28f. Location (Str City or Town	Stete)	er or mura	il Moule (vumber,
the Hospital ithin 24 hours of the Funeral mplately filled	29e. Certifier 1 Certifying F	hysician: 76 the best of my knowning: On the basis of exemin-	owledge, etion end	deeth occurred et the till for investigetion, in my o	me, dete end plec opinion, deeth occ	e, and due to the ca urred at the time, da	use(s) end me te end plece,	and due to	tated. the ceuse(s)
within 2 To the comple	one)	end menner steted.		29c. Licens	a number	200	d Data siana	d /Manth	Day Veed
P N N N N N N N N N N N N N N N N N N N	29b. Signeture end title of partition	Gyazzo, M.D.		Maryl	and Do 2	2159 De	d. Date signe cember	27,	2000
year	(-	2 4 pa							
Alos	30. Nama and address of a sun with				r'01 0		a		(T)
1 1 1		, M.D., Maryal	nd 1	niirmary, 2	25343 Hur	rry Road,	Chapti	co, l	m 50951
State	31. Data filed (Month Day, Year)	32. Registrer's Sign		4 1					
Registrar	DEC 28	מחחים אינים		B. Some	de.				



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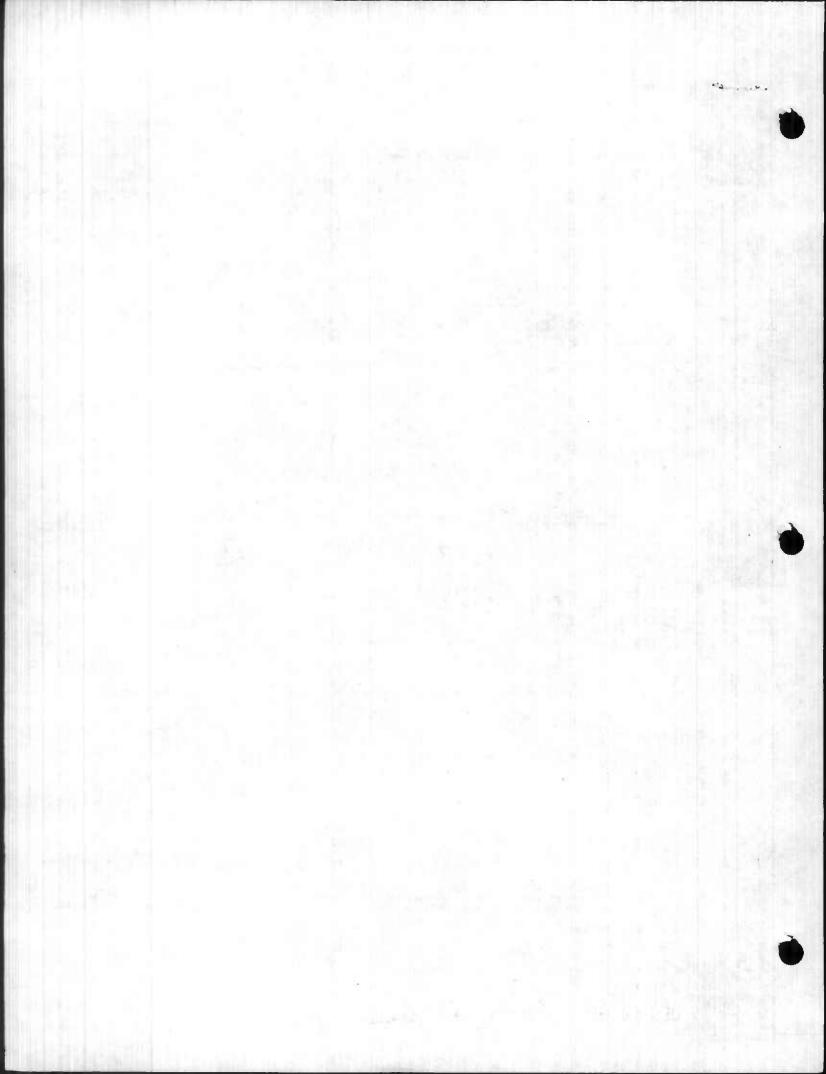
State of Maryland / Department of Health and Mental Hygiene 0 0 4 2 4 0 3

1. Decedent's Nama (First, Middla,	, Last)	061	rtificate of	Douil	2. Data of Death		3. Time of Death
RHODA VIOLET D	ODD				Month DECEMBE	Day = 14 >	1:05 pm
4a Facility Nama (If not institution,	, giva street and number)			4b. City, Town, or L		4c. County	
Doctors Hospit	al al			Lanham,	MD	Prince	e Georges
5. Social Security Number		yrs. last birthday)	If Undar 1 Yaar Months Days		8. Data of Birth (Month, Day,	Year)	Birthplaca (Stata or Foraign Country)
579-404651	1□M 2 □F 69	Yrs.	MORITA Days	Tiodis Will.	11-29-3	1	New Jersey
Usual Rasidence of Decedant 10a. Stata 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	e Georges	Seat Ple					1 △Yas 2 No
10e. Street and Number	e Georges	Seat Fit	101. Zip Coda		10	g. Citizen of W	That Country?
6211 Foote Stre	0.4		20743	2		USA	not oddiniy.
11. Marital Status	12. Was Decedent Evar	in U.S. 13.1			pecify Yas or No-		- Amarican Indian,
1 Nevar Marriad 2 Marrie	Armed Forcas?			Hispanic Origin? (Span, Maxican, Puart	Rican, atc.)		c, Whita, atc.
3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yaar or Datas:		1□Yas 2∰No	Specify:		Specity:	Black
15. Decedent' (Specify only highest	's Education	16a. Dece	dant's Usual Occu	pation during most of wor.	king 1	6b. Kind of Bu	siness/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)					D	
10th			Housewife			Private	
17. Fathar's Nama (First, Middla, L	Last)				na (First, Middle, M	laidan Sumami	в)
Thomas Vance					Fuller		
19a. Informant's Name/Ralationsh				Park Road			
Eloise Jones/ D 20a. Method of Disposition							City or Town, Stata
1⊠ Burial 2 □ Cramation	3 LIMamoval from Stata		osition (Nama of matory or other pla	- 1		helten	
4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		-	Veterans	1		Merceni	ialli, rib
21. Signatore of Furieral Service C	4			ass of Facility Kins Fune:			2205
2 Part February	and in the state of the state of the			dover Rd.			
23a. Part1. Enter the diseasa, or o shock, or haart failura. List o	only ona causa on each line.	daath. Do not am	ar tha moda or dy	ing, such as cardiac	or raspiratory and	, st,	Approximata Interval Batween Onset and Death
Immediata Causa (Final	(=1.011)	11000	CCAI	CEDC	10		DAVIC
Immediata Causa (Final disaesa or condition rasulting in daath)	a STAPHY			2612	15		DAYS
		to (or as a consec	quance or):				DAUC
Sequentially list conditions	D	to (or as a consec	uence of):				1 711 2
Sequentially list conditions, if any, laading to Immadiata ceuse. Enter Undarlying Ceuse (Disease or injury	0	ESTIV		ART +	CAPLU	IRE	DAYS
Ceuse (Disease or injury that initiated events resulting in death) Last	0.	to (or as a consec		. , , , ,	17100	114	
resulting in Country Last	. CORON	IARY	ARTE	ERY :	DISEA	HRE	YBARS
	d. Corcor	7711-	111111				
Part II. Other significant condition	ns contributing to death but no	t rasulting in tha u	ndarlying causa gi	ivan in Part I.	23b. Did to	bacco uae con	stribute to the cause of death
DIABLIE	S MEL	LITU	<		1 □ Ye	2 D No	3 Probably 4 Unknow
0					24a. Was ar	a autonou	24b. Ware autopsy findings
KENAL	FAILURI				perform		available prior to completion of causa
1440000	10 - 00	1	mark.				of death?
	ENSION	J			1 ☐ Ya		1 Yas 2 No
25. Was casa referred to medical axaminar?	Hospital:		_ 0	ther	ith (Check only on		
1 Yas 2 No	1 Minpatient 28a. Dete of Injury	2 ER/Outpatier	nt 3LI DUA	4 Li Nursing H	oma 5 Raside		
	(Month, Day Ye	ar) Injury	Wo	ork? Yas 2 No	200. 2000100110		
27. Manner of Death 1 ☑Natural 5 ☐ Pending	W1.011	At homa, farm, str			28f. Location (St	reet and Numb	er or Rural Route Number,
27. Manner of Death 1 Natural 5 Pending 2 Accident Invastig 3 Suicida 6 Could n	ot be 28a. Place of Injury -		,,		City or Town	, State)	
27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident Invastig	28a. Place of Injury - building, etc. (S	pecify)					
27. Manner of Death 1	building, etc. (S)	pecify) v knowledge, deatl					
27. Manner of Death 1	building, etc. (S	pecify) v knowledge, deatl					
27. Manner of Death 1 Natural 5 Pending 2 Accident Invastig 3 Suicida 6 Could n 4 Homicide datarmii	physician: To the best of my Examiner: On the basis of axa	pecify) v knowledge, deatl	vastigetion, in my		rred et the tima, de	ita and plece, a	and due to the ceuse(s) i (Month, Day, Year)
27. Manner of Death 1 Natural 5 Pending 2 Accident Invastig 3 Suicida 6 Could n 4 Homicide datamii 29a. Certifier 1 Certifying (Check only one) 1 Medical E	physician: To the best of my Examiner: On the basis of axa	pecify) v knowledge, deatl	vastigetion, in my	opinion, deeth occu	rred et the tima, de	ita and plece, a	and due to the ceuse(s)

State Registrar DEC 2 0 2000

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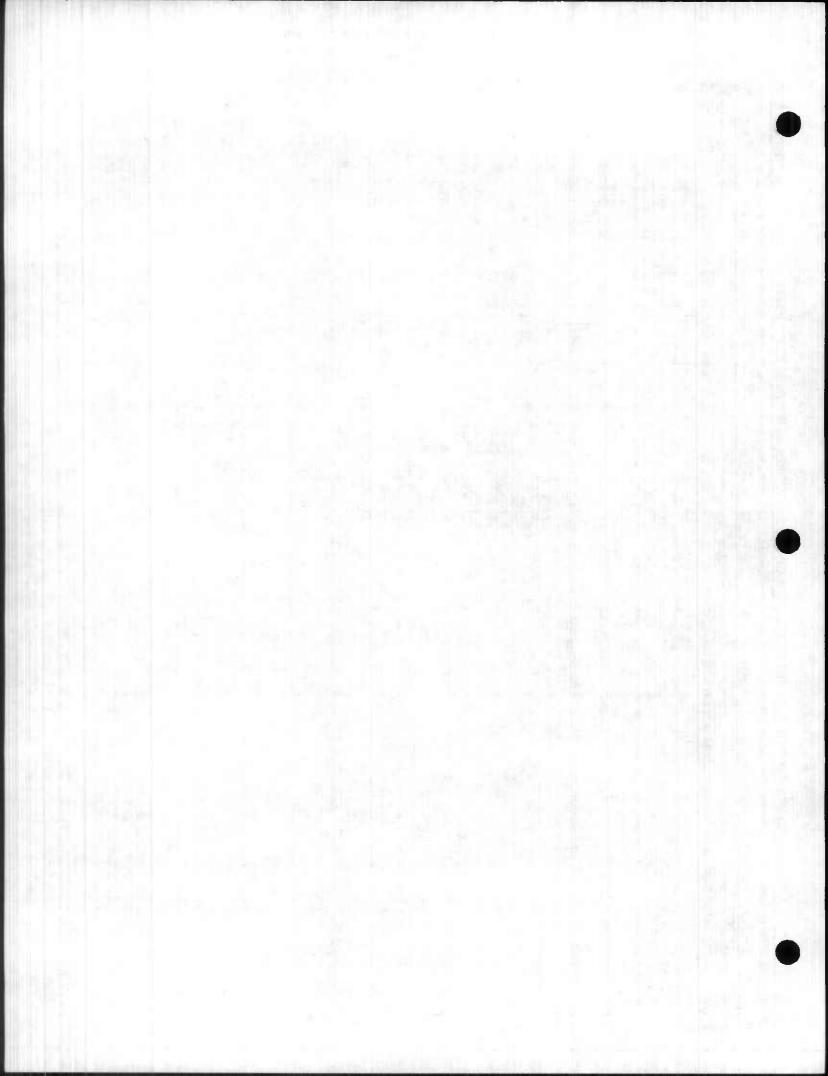
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State of Maryland / Department of Health and Mental Hygiene U U 4 2 4 0 4

			Certificate of	Death	Reg	. No.			
	1. Decedent's Neme (First, Middle, Las	1)	The date		2. Deta of Deeth	D. V	3. Time of Death		
Physician	GEORGE FRANK	LIN DOWNS			Dec. 26	, 2000 Y	6:06 AM		
/Medical Examiner	4a Facility Neme (If not institution, give			4b. City, Town, or L		4c. County of			
LXamiller	Civista Medical Co			La Plata		Charle			
Funeral Director	578-28-6082	7. Age (In yrs. last b XM 2□ F 74	oirthdey) If Under 1 Year Months Deys		8. Dete of Birth (Month, Dey,) May 16,	1926 T	Birthplace (State or Foreign Country) WAShington, DC		
D	Usual Residence of Decedant 10a. Stete 10b. County	10c. City. To	wn or Location				10d. Inside City Limits		
a Maryli art sho iffied at	MD Charles		njemoy				1 Yes 2 No		
doeth with the Maryla rms 23a or 28a-f shor r.msst.be.notified at neral Director	10e. Street and Number 3875 Oak Grove P	1200	10f. Zip Code	0662	109	g. Citizen of Who	et Country?		
020 urs after at, or its Examine by Fu	11. Maritel Stetus 1 □ Never Merried 2 ☑ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent Evar in U,S. Armed Forces? 1 12 Yes 2 1 No 1945— H Yes, Give Year or Detes: 1947	13. Was Decedent of If Yes, specify Cul	Hispenic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White		
215-002(thin 72 hours a in 'netural', o Medical Exam spletted by	15. Decedent's Edu (Specify only highest grad		e. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin	pation during most of work	sing 16	6b. Kind of Busin	ness/Industry		
27215-0 ed within 72 ho operation mature it the Medical Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Mechanic	90)		Auto			
Be C	17. Father's Nema (First, Middla, Last)			18. Mothar's Nam	e (First, Middle, Ma	aiden Sumeme)			
Via Manifest To To	Joseph Stephen Dov	vns		Effie E	. Dought:	rey Down	ıs		
Mar d 2 sh th and t7 is m	19e. Informent's Neme/Reletionship (T) Helene C. Downs/Wi	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	9b. Meiling Address (Stree 3875 Oak G1						
f Hsa other other	20e. Mathod of Disposition	cemer	of Disposition (Nama of tery, cremetory or other plants				ty or Town, Stata		
Pages neared wit: If the ury or o	1 Suriel 2 Cremation 3 4 Donetion 5 Other (Specify,	Removel from State	Family Ceme		/29/00 Na	anjemov,	MD.		
Ball permit. Departrimports any infi	21. Signetup of uneral Service Licens	M00945	AREHAR	ess of Fecility C-ECHOLS F	UNERAL HO	OME, P.A.			
	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. De		OX 567 LA ing, such as cardiac			Approximete intervel Betwaen		
Physician /Medical Examiner	Immediete Ceuse (Finel disaase or condition resulting in deeth)	1,	chroke Car e consequence of):	diovasai	las des	lase	Onset end Death		
Gox bo four death certificate be executed e attending physician and d for use as the bunal-transit sician/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Lest	c. renal	a consequence of): faulum a consequence of):	farlun					
death ce attendii d for use	Part II. Other significant conditions co	ntobuting to death but not resulting	in the underlying cause of	iven in Pert I	23h Did toh	acco use contr	ibute to the cause of death?		
Phys the detached	Tarri. Other algunicality continues co	minuting to death out not resulting	y in the diluenying cause g	ivor ar t ott.	1 Yes 2 No 3 Probably 4 0				
ecords, ew requires ts been sign 2 should be					24a. Was an		24b. Were autopsy findings available prior to completion of cause of deeth?		
The lew ate has page 2					1 ☐ Yes	2₽No	1 Yas 2 No		
elclen: The certificate lirector, pag	25. Was case referred to medical examiner?			26. Place of Dee	th (Check only one)			
H Sign	1 ☐ Yes 2 ☐ No 27. Menner of Deeth 1 ☐ Natural 5 ☐ Pending	Hospitel: 1 Inpatient 2 ERX 28a. Dete of Injury (Month, Dey Year)	Dutpatient 3LI DOA D. Time of Injury W	ury et ork?	oma 5 Residen				
C the ear	2 Accident investigation 3 Suicida 6 Could not be 4 Homicide determined	28e. Plece of Injury - At homa, building, etc. (Specify)		Yes 2 No	28f. Location (Stre City or Town,	eat and Number State)	or Rurel Route Number,		
To the Hospital or Atl within 24 hours atterd To the Funeral Direct completely filled in by Medical Certifi		sician: To the best of my knowled lner: On the bests of examination a and menner stated.							
Me of the	29b. Signeture end title of certifiar	1111	29c. Licar	nse number	29	d. Date signed (Month, Day, Year)		
F 5 F 0	1	Haer	D-00	22574	- /	2/26/5	00		
	30. Neme and address of person who c	ompleted ceuse of deeth (Item 23s	a) (Type, Print)			-1-11			
	Robert T. Pace, MD	12070 Old Line	Center, Sui	te 202. W	aldorf Ma	ryland	20602		
State Registrar	31. Dete filed (Month, Dey, Year)	Oz. Hogistians Digitatura	, A L	a de 1		z y zanu ".	20002		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day **Physician** Lawanna Jane Dulev December 17, 2000 0742 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prixice George's Upper Marlbors Rosany ville RoAd If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Euneral** Days 10 M 25 F 56 577 56 9744 Director May 3, 1944 Washington DC Usual Rasidance of Decedent the Maryland 10b County 10c. City, Town or Location 10d. Insida City Limits th and Mantal Hygiene.

7 is marked other than "natural", or frame 23a or 28a-f show traumatic avent, the Medical Exame for must be notified. 1 Yas X No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9956 Rosarvville Road 20772 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - Amarican Indian Black, Whita, atc. filed within 72 hours after 1 Yes 2 No 1 Nevar Married 2 Married 1 Yas XX No Specify: 21215-0020 by White XX Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Title Examiner D.C. Government Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Pages 1 and 2 should be 1 nent of Health end Mental I int: If item 27 is marked of Garland Winfield Hallman Grace M. Hawkins 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 9956 Rosaryville Road, Upper Marlboro, MD 20772 David B. Watkins (FIANCEE) or other 20b. Place of Disposition (Nama of cematery, cramatory or other place)

Dec 21, 2000 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If any Injury or once. Maryland Veterans Cemetery Cheltenham, Maryland 21. Signatura of Furneral Service Licensi 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter tiffé disease, or complication shock, or haart failura. List only only care ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximata Interval Batwe Onsat and Death Physician Inflyenza /Medical fmmediata Causa (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of) Physician/Medical Examine lcian end bunal-transit The law requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasse or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Dua to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 1 Yas 2 No 1 Yas 2 No Division of Vital or Attending Physician: 25. Was casa rafarred to medical Certification: To Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residanca 6 Othar (Specify) 10 Yas 2 No After this funeral 28a. Data of fnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Pending investigation 1 Yas 2 No within 24 hours after death. To the Funeral Diractor: A 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 2 28a. Place of fnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida Hospital 1 Cadifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar edical (Check only one) ş 29b. Signatura and titla of certifier 29c. License number 29d. Data signad (Month, Day, Year) 2 00

State Registrar

DHMH 16 Rev 6/95

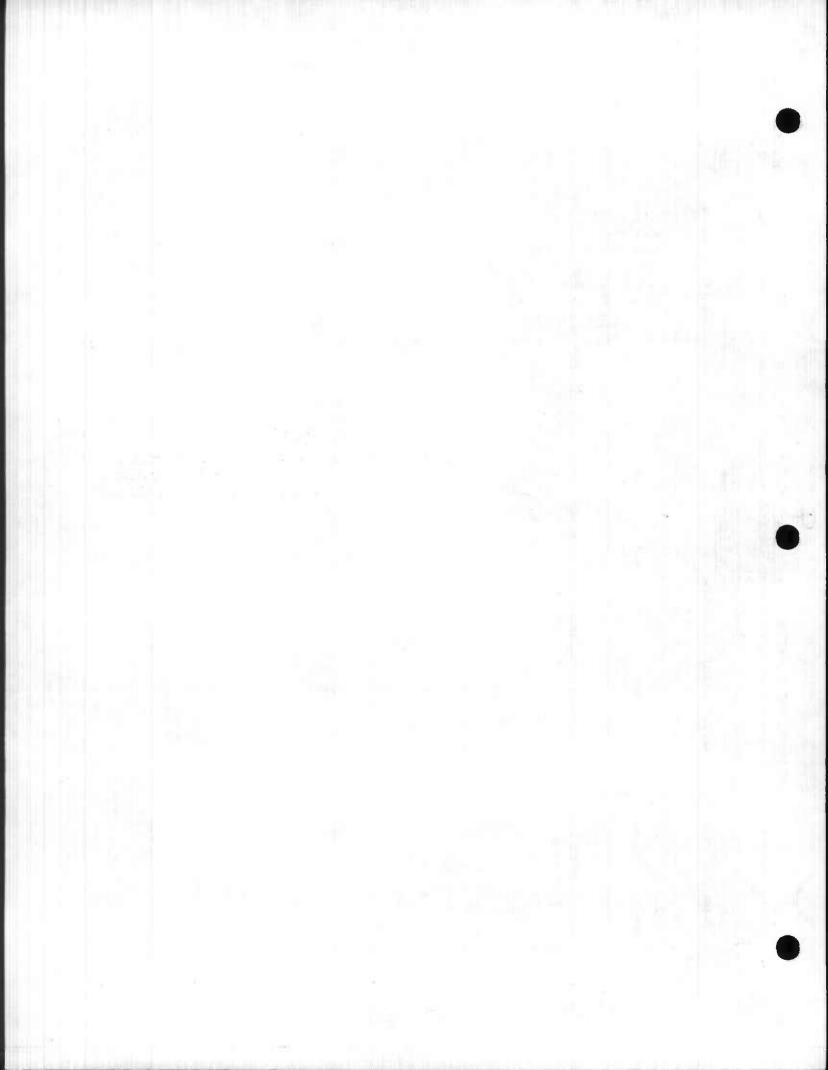
3001 Hospital Dring

32. Registrar's Signatura

Cheverly Maryland 20785

30. Nama and addrass of parson who completed cause of death (Item 23a) (Type, Print)

y/vster



Piease Type or Print in Biack Indeiibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 23a per md G791 1/4/01 yf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 10,2000 Mitchell Dennis Sr. 8:05 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7262 Truitt St. Willards Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 18 M 2□ F Months Deys Hours Yrs. Director 220-12-2428 July 27,1924 76 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow ahow 1 No 2 No Director Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 ma 23a 7262 Truitt St. 21874 USA death Funeral Rema 2 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status "natural", or iter Black, White, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Year or Detes: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If Itam 27 Ia marked other than "say Injury or other traumatic avent, the Mark Elementary/Secondary (0-12) College (1-4or 5+) 8 Farmer & Poultryman Own Farm 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) 8 0 Lawrence Grant Dennis Bessie Davis 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7262 Truitt St. Willards, MD 21874 Jeanette W. Dennis- Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dennis Cemetery 11-13-00 Willards, MAryland 21. Signature of Fuperal Service License 22. Name end Address of Fecility 705 E. Main St. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Salisbury, MD 21804 Approximete Interval Between Onset end Deeth **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical CHOLANGIOCARCINOM 2455 Examiner Due to (or es a consequence ot): Physician/Medical Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physicien end the burlai-tran Due to (or es a consequenca ot) 68760 Due to (or es e consequence of): 8 Box P.O. 23b. Did tobecco use contribute to the cause of death? Pert It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the 1 Yes 2 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed' 1□ Yes 2□No 1 TYes 2 No Division of Vital Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturat 5 Pending investigation Ne Hospital or Attanding n 24 hours after death. Ne Funeral Director: Afti pletely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 To the 29b. Signature and title of certifle 29c. License number 29d. Date signed (Month, Day, Year) 10100

State Registrar

Chris Snyder MD 106 Milford St. 32. Registrar's Signature

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Salisbury, MD 21804

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42407

				Certifica	ate of Death	F	leg. No.		
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Examin		4e. Fecility Neme (If not Institution, giv			4b. City, Town, o	r Location of Deeth	4c. County	of Deeth	
	Ш	Westminster N	ursing Hom	c	Westmi	nster	Ca	rroll	
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or Rems	Funeral Director	1 Never Married 2 Merried	Armed Forcas?	If Yes, s	edant of Hispanic Origin? (secify Cuben, Mexican, Pua	irto Rican, atc.)	Blec	k, White, a	
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Department of Health er Important: if itam 27 is any injury or other trai ance.		21. Signature of Funerel Servica Licer			end Address of Facility			, ,	11.
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neral y fille		29a. Certifier 1 Certifying Ph	yaician: To the best of my kno	wledge, daath occurre	d et the time, dete and plac	ce, end dua to tha c	eusa(s) end me	nner es ste	ated.
Fu Fu	edicai	(Check only 2 Medical Examone)	niner: On the besis of axemina end mannar stated.	tion end/or Investiget	on, in my opinion, death occ	curred et the tima, o	late and plece, e	end due to	tha ceuse(s)
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21		31. Data filed (Month Day Year)	30 Ranietario Sino	o local	1 Water	0700000			7/
To the Hospital or Attanding Physician: The I within 24 hours effect death. To the Funeral Director: Afferthis certificate he completely filled in by the funeral director, page	X	29b. Signature end title of certifier	end manner stated. completed cause of deeth (Item 32. Ragistrar's Signe	n 23e) (Type, Print)	9c. License number		29d. Dete signed		_

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death DECEMBER Day 4, 2000 8:30pm Physician KATIE BYRD EVANS /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES 7. Age (In yrs. lest birthdey)
73 Yrs. If Under 24 Hrs. If Under 1 Year Dete of Birth (Month, Day, Year) JANUARY 9. Birthplace (State or Foreign Country) 30, 1927 SOUTH CAROLI 5. Sociel Security Number Funeral 1 M 2 XF Director 250-40-0917 Usuet Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 15 1/1亿 XX Yes 2 □ No Director MD PRINCE GEORGES FORESTVILLE 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 20747 UNITED STATES 2020 BROOKS DRIVE Funeral 14. Reca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK P 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elemantary/Secondary (0-12) Collega (1-4or 5+) BEAUTICIAN PRIVATE marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Peges 1 and 2 should be fill Department of Heelth and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic even Be ALBERTUS MCBRIDE DORETHA BROWN 19e. Informent's Name/Beletionship (Type Print) 19b. Melting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JANICE McBRIDE / GRANDAUGHTER 6506 BUCKLAND CT. FORT WASHINGTON, MD 20744 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stete cemetery, cremetory or other piece, 1 Deuriel 2 Cremetion 3 Removel from State FORT LINCOLN CEMETERY 12-22-00 BRENTWOOD, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Furrerat Service lucerisee 22. Name ALEXANDER SINS. POPE FUNERAL HOME Lymais Den 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onset end Death Physician /Medical Immediate Cause (Final Congestion heart trilune diseese or condition resulting in death) Examiner Examiner Broncho preumonia Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated evants rasulting in deeth) Lest Due to (or es e consequence of) Hypertensive Carolismys, Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part It. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 signed b P 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Was en eutopsy Completed peen : 1 Nes 2 No 1 PYes 2□ No certificate or Attending Physician: director. Be 25. Wes cese referred to medical 26. Piece of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After thi 28e. Data of Injury (Month, Day Year) 27. Menger of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Netural 5 Panding death. 1 Yes 2 No Investigetion 2 Accident Director: 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Discompletely filled in 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12. 20.00 Roiston Farahiten M.O. 30. Name and eddress of person who completed ceuse of deeth (item 23a) (Type, Print) 9801 Georgia Ave suit 3-35 SILVER SPRING MD 20902 ROINTAN FARAHIFAR

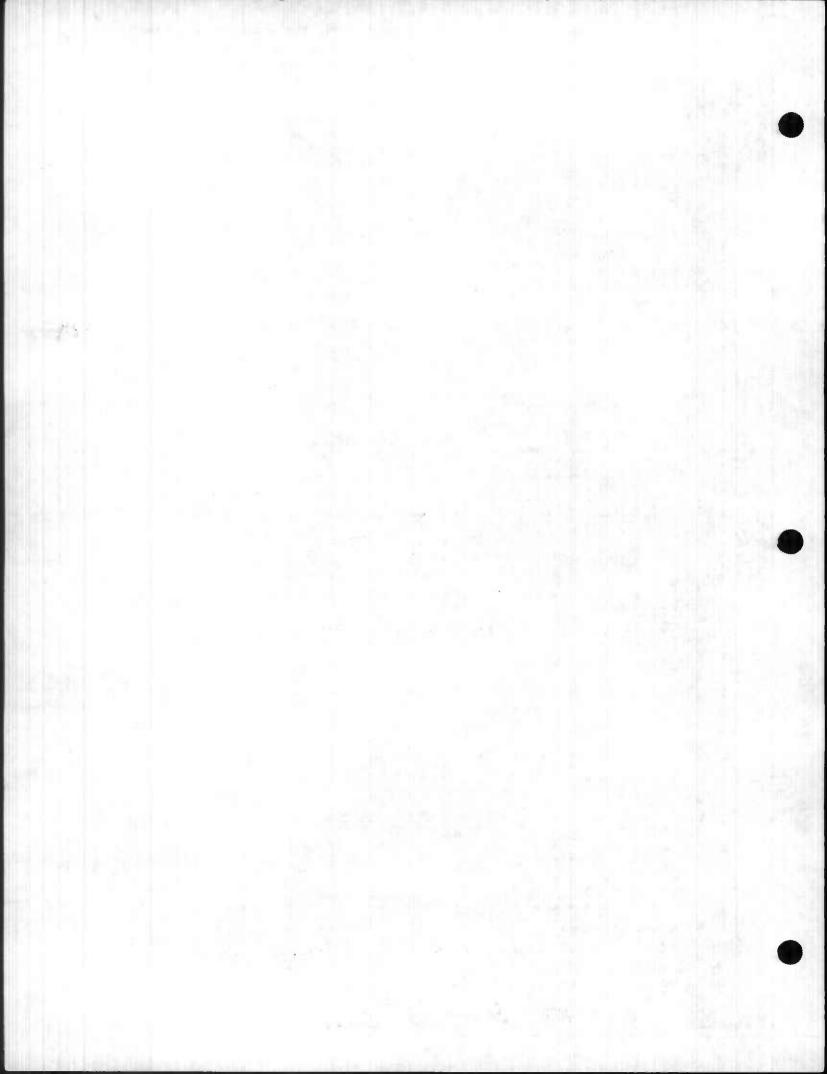
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31. Dete filed (Month, Day, Year) DEC 2 2 2000 32. Registrer's Signeture

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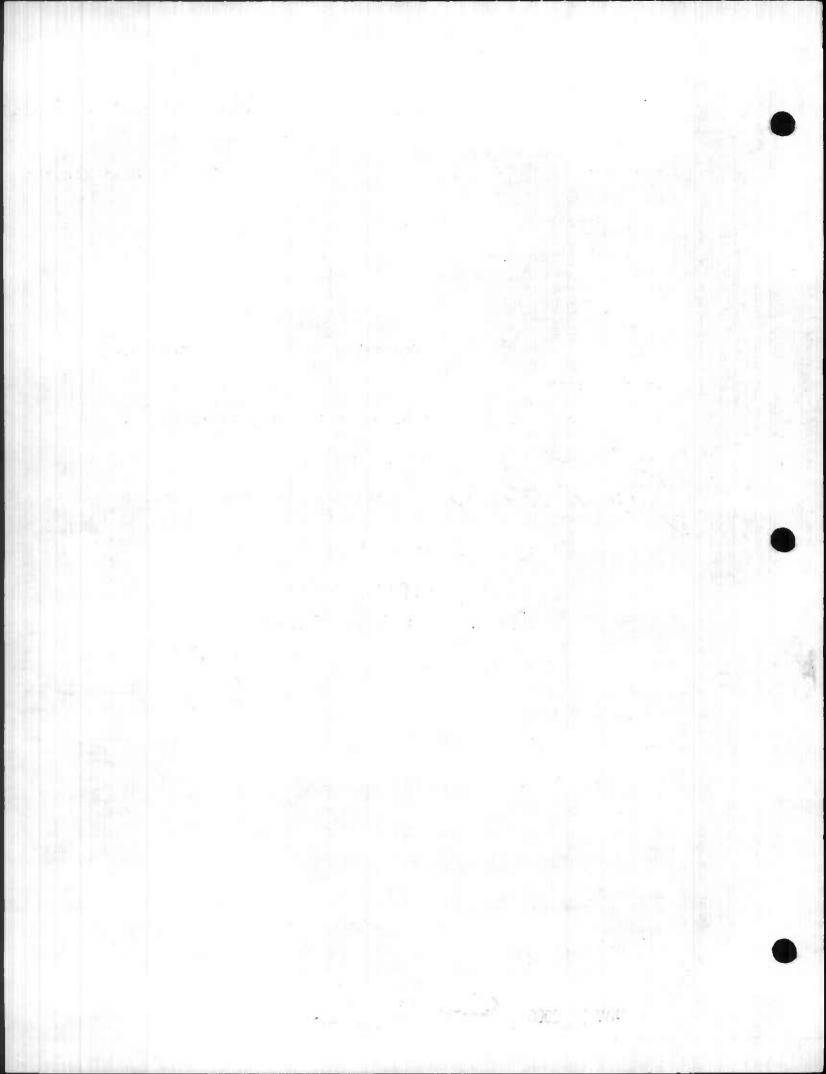
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item#30 HCHD 12-29-00 Certificate of Death brh Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician Ellen E. Evans /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner tizens Nursing Home Under 24 Hrs If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Hours 1□M 25 F Yrs. 79 Director 213-52-9757 West Virginia Usuel Residence of Deceden 10a. Sfete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Havre de Grace 1X Yes 2 □ No Director MD Harford 415 S. Market Street 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 415 S. Market Street 21078 United States Funeral 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Yes 2 🔯 No If Yes, Give Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White P 3 Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mental Injury Elementery/Secondery (0-12) Collega (1-4or 5+) Homemaker Own Home 5 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Martin V. Evans Edna Christie 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informent's Neme/Reletionship (Type, Print) Chester Evans/Brother P.O. Box 627, Kitzmiller, MD 20b. Plece of Disposition (Name of cametery, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Evans Eagle Crematory 10/31 Leola, PA 21. Signature of Funerel Service Licenses 22. Name end Addrass of Fecility Harkins Funeral Home, Inc., Delta, PA En 5r the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, k, or haart failura. List only ona cause on aach lina. Approximate Intarval Batween Onset end Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in deeth) Examiner Examir Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in daath) Last pue Physician/Medicai winnym 23b. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 D Onknown by Records, 24b. Were eutopsy findings evailable prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed 2 No 1 ☐ Yes of Vital 25. Wes casa referred to medical exeminer? 26. Place of Death (Check only ona) To Hospitel: Other: Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manyer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After Division 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident of after deat Director: 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could nof be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and dua to the cause(s) and mennar steted. 29a. Certifier edicai (Check only 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dev. Year) (4WD 0 30 00 40 Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) 319 S. Union Ave. Havre De Grace, Md 21078 strer's Signature (Month, Day, Year) State NOV 1 2000 Registrar **DHMH 16 Rev 6/95**

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey December 9, **Physician** 2000 1952 Agnes Theresa Ford /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner 46516 Walnut Court St. Mary's Lexington Park If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) August 23, 1907 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1□ M 25 F 217-72-8488 Yrs. 93 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland St. Mary's Lexington Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 46516 Walnut Court 20653 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Black, White, etc. or items 11 Maritel Status filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 Widowed 4 □ Divorced White "natural", 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th Homemaker Own Home Ith and Mental Hygie 27 is marked other r traumetic avant, II Saltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hism 27 is marked out Be Thomas Emanuel Higgs Florene Lucretia Bowles 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) pemit. Pages 1 and 2.
Department of Health as Important: If Item 27 is any injury or other trau Fairfax (Daughter) 46516 Walnut Court, Lexington Park, Maryland 20653 Mary Berenice 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition ☑Buriel 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Gardens 12/12/00 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licenses Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Ieonardtown, Maryland 20650.

23a. Pert 1. Enter the disease, or complications that ceused the death of not enter the mode of dying, such as cardiac or respiratory errest,

Approximately 1. Compared to the ceuse of the death of the mode of dying, such as cardiac or respiratory errest,

Approximately 1. Compared to the ceuse of the death of the mode of dying, such as cardiac or respiratory errest,

Approximately 1. Compared to the ceuse of the Approximate Interval Between Onset and Death Physician Cardinenelar /Medical Immediate Cause (Final ATheroclerile diseese or condition resulting in death) Examiner Due to (or es e consequence of Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of) Box 68760. Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by 24b. Were eutopsy findings availeble prior to completion of cause of death? 24a. Wes an eutopsy 1 ☐ Yes 2 No Division of Vital or Attanding Physician: Be 25. Wes cese referred to medicel examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 2 No ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred Medical Certification: To 1 ☐ Yes 27. Manner of Deat 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 1 A Natural Accident 5 Pending investigation after deeth. Diractor: Aft 1 Yes 2 No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner steted. 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature at title of certifier 12-11-00 014285 30. Neme end address of person who of ceuse of deeth (Item 23a) (Type, Print) Leonardtown, Maryland 20650 William Boyd, II. MD

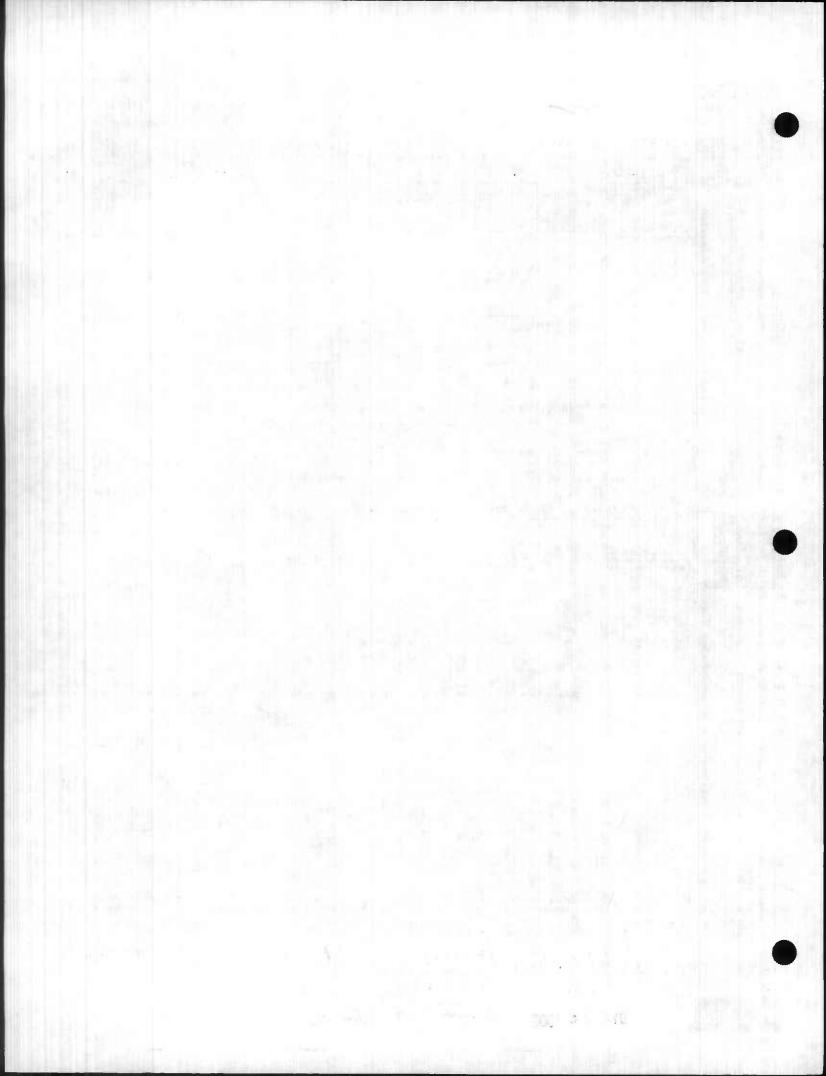
DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

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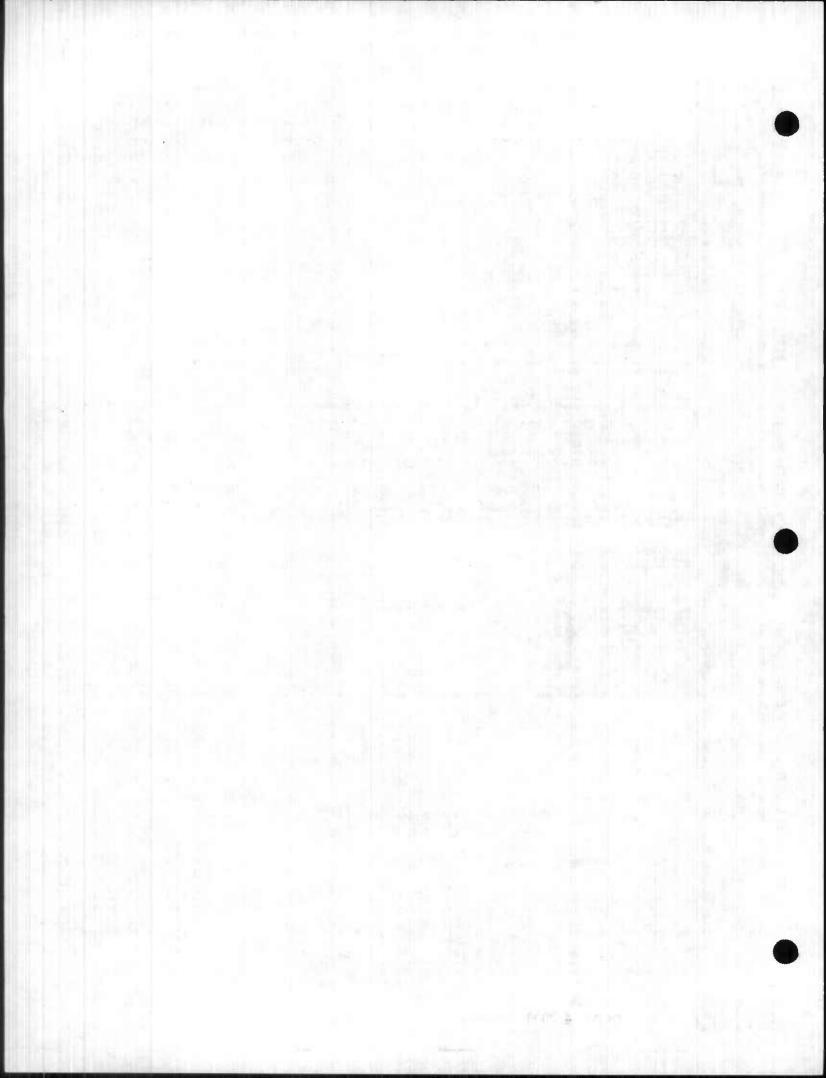
32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U 0 424

		CONTRACTOR OF THE PARTY OF THE	Ce	ertificate of	Death		Reg. No.		
	1. Decedent's Name (First, Middle, La	st)				2. Date of De		Year	3. Time of Death
Physician /Medical	Hyacinth	Juanita	Fowler			Novembe	000		11:33 A
Examiner	4a Fecility Neme (If not institution, giv	e street and number)			4b. City, Town, or l	ocation of Deef			
Examina	Solomons Nursin	Center		F1 40	Solomons		Calve	rt.	
Funeral	5. Social Security Number 6. S		n yrs. last birthdey) If Under 1 Yeer	If Under 24 Hrs.	8. Date of Bir (Month, Da			laca (State or Fore
Director	264-72-9129	□M 2√F	90 Yrs.	Months Deys	Hours Min.	January	13, 1910	Wheh	ingtan, DO
	Usual Residence of Decedent					1 -52.25.27			2.502.7
N M	10a. Stete 10b. County	10	Oc. City, Town or I	Location				1	0d. Inside City Lir
to feet	Maryland Charl	es	Bened	dict					1 ☐ Yes 2 ☐
or 28e-fr	10e. Street and Number		20110	10f. Zip Code			10g. Citizen of W	hat Coun	try?
2 2	P.O. Box 222			2061	2		U.S.A		
t liens 23e or 28e-f sho sher must be notified at Funeral Director	11. Merifel Status	12. Was Decedent Eve	r in U.S. 13			pecify Yes or No			an Indian,
	1 ☐ Never Merried 2 ☐ Merried	Armed Forces? 1 ☐ Yes 2 ☑ No		. Was Decedent of I If Yes, specify Cub	en, Mexican, Puert	o Rican, etc.)	Black	, White,	etc.
by F	3 X Widowed 4 Divorcad	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	Wh	ite
	15. Decedent's Ed		16a Dec	edent's Usual Occur	pation		16b. Kind of Bus	iness/Inc	lustry
r, the Medical Completed	(Specify only highest gra	ide completed)	(Giv	edent's Usual Occup re kind of work done DO NOT use retire	during most of wor	king			
The Man	Elementery/Secondery (0-12)	College (1-4or 5+)		memaker			Own Hor	ma	
	17. Fether's Name (First, Middle, Last,	,	1101	IICIIIANEL	18. Mother's Nen	ne (First, Middle	, Maiden Sumame		
ed off					Catheri Pearl	ine			
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rand	19a. fnformant's Name/Relationship (iling Address (Street					(1000
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or of	20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐		cemetery, cr	ematory or other pla			200. Location - (ny or 10	WII, SIBLE
and and	4 Donation 5 Other (Specif		Cedar Hil	1 Cemetery		12/4/00	Suitland	, Mar	yland
attending physiclen end I for use as the burial-transit Clan/Medical Examiner	Ceuse (Disease or Injury that initieled events resulting in death) Last Due to (or es e consequenca of):								
9 %	Part II. Other significent conditions of	ontributing to death but n	of resulting in the	underlying cause gi	ven in Pert I.	23b. Dfd	tobacco use con	tribute to	the ceuse of de
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signed I d be det									
shoul ete							s an autopsy ormed?	av	ere eutopsy findir ailable prior to mpletion of causi death?
pege 2						10	Yes 20 No	1[Yes No
E 0 0	25. Was case referred to medical				26. Place of Dea	ath (Check only	one)		
	examiner?	Hospitel: 1 Dinpatient	2 ER/Outpati	enf 3 DOA Ot	hor		idence 6 □Othe	r (Snecil	(v)
6 =	27. Menner of Deeth	28a. Date of Injury	28b. Time	of 28c. Inju		-	how injury occurre		,,
at Director: After the din by the funeral Certification:	Natural 5 Pending investigation	(Month, Day Y	ear) Injury		ork?]Yes 2□No				
ector: by the tifica	3 Suicide 6 Could not b		- At home, farm	street, factory, office		28f. Location	Street and Number	er or Rure	al Route Number,
Director: A in by the d in by the dertificat	4 Homicide	building, etc. (City or To	wn, State)		
Funer tely fill		ysicien: To the best of miner: On the basis of ex and manner stated	amination and/or						
To the comple	29b. Signature end title of certifier	and marker stated		29c. Licen	se number		29d. Date signed	(Month.	Day, Year)
F 8		1/10	110				Decemb		
	Jan y	1 andro M	3		17610		Decemb		1 2000
	30. Neme end address of persopowho				ndori als	Marralar	nd.		
	David J. Tard			Prince Fr	edelick,	rarytal	I.u.		
State	31. Dete filed (Month, Day, Year)	32. Registrar's	Signature	4. Soon	10				
Registrar	DEC 4	2000	1	J. Soon	RN				



Please Type or Print in Biack Indelible ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Year Ralph Edward French December 19, 2000 12:57PM 4e Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Caroline Nursing Home, Denton Caroline If Under 1 Yeer If Undar 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Steta or Foreign Country) Davs Months 1**™**M 2□ F Hours Yrs. 70 December 16, 1930 Delaware 222-18-2649 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 369 Glebe Road 21601 United States 12. Was Decedent Evar in U,S.
Armed Forces?

120 Yes 2 No 1952 If Yes, Give
Yeer or Detes: 1954 11 Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 ☒ No Specify: Specify: Caucasian 3 Widowed ODDivorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Construction worker 6 Self-employed 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) George Edward French Elsie Laura Meeds 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Darrell L. French Son 369 Glebe Road, Easton, Maryland 21601 20a. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, State Maryland Eastern Shore tx Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 Donation 5 Other (Specify) Veterans' Cemetery 12/22/00 Hurlock, Maryland 22. Name and Address of Facility
Moore Funeral Home, P.A. 5020 12 South Second Street, Denton, Maryland 21629 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear teilure. List only one ceuse on each line. Approximete Intervel Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es e consequence of) Dua to (or es a consequence of): Dua to (or as a consequence of):

Physician /Medical Examiner

The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

ate has been signed by the attending physicien end pege 2 should be detached for use as the burial-tran

After this certificate has

To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; 5

Physician/Medical Examiner

þ

Completed

Be

Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

ehow

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traumetic event, the Medical Examiner must be notified at

Funeral Director

Completed by

with the Maryland

death

permit. Peges 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural!" Any Injury or other traumatic average.

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

25. Wes cese reterred to medical

29b. Signature and title of certifier

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy 24b. Ware eutopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No

29d. Data signed (Month, Day, Year)

26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1- Neturel 5 Pending investigation Injury 1 TYes 2 No 2 Accident 3 Suicide

6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28a. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide

29c. Licanse number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

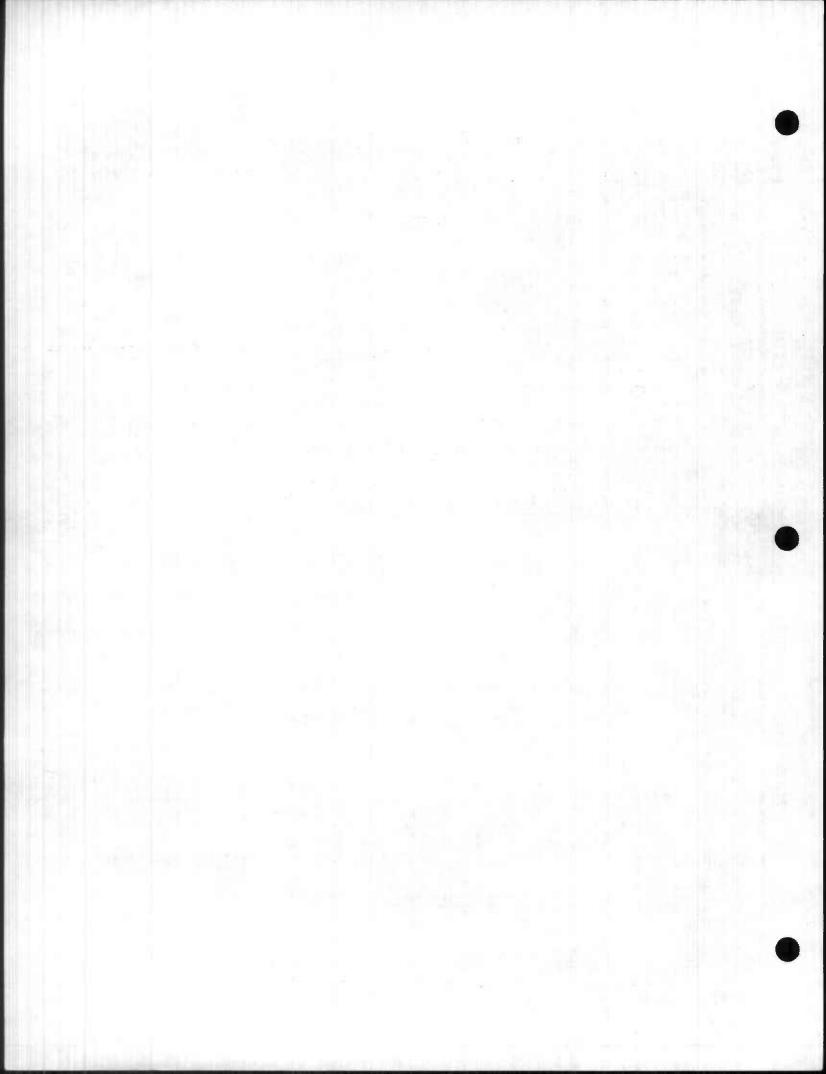
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifiar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PO Box 496, Denton, Maryland 21629 James Sides, M.D.,

State Registrar

31. Date tiled (Month, Dey, Year) 32 Registrer's Signeture DEC 2 0 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 2 4 3 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day Year **Physician** TAMES DUNBAR FRASER December 0330 14 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age /In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 F Months Days Hours Yrs. 060-34-5921 57 Director January 4,1943 New York Usual Residence of Decedent r 28a-f show 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Florida Director Broward Deerfield Beach 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ne 23a or 2 842 South East 19th Ave., #3 33441 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Status "natural", or item Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: AirForce 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. White by 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mentel Phylene. Important: If item 27 is marked other than "natur any injury or other traumatic event, in market 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Furniture Sales Sales 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Fraser Martha Crawford 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Ellen Moran Fraser/Wife 842 South East 19th Ave #3, Deerfield Beach, FL 33441 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/14/00 Salisbury, MD Salisbury Crematory 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Service In 501 Snow Hill Rd., Salisbury, MD 21804 CFSP roway 23a. Per1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 6 gal Conebrancocalon acciden Examiner Due to (or as a consequence of) Examine Mon physicien and s the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last 68760 Due to (or as e consequence of): certificate be Physician/Medicai Box 9SD Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o signed by t 1 Yes 2 No 3 Probably 4 Unknown 0 by Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No After this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Menner of Death Division Attending 5 Pending Investigation 1 Matural 1 Yes 2 No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 5 24 hours 1 Gertifying Phyeicien: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 140050783 12-28 1,00 1VA 30. Neme and address of or wife completed cause of death (Item 23a) (Type, Print) DQ Pensuden Luderlas 1201

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

32. Registrar's Signature

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DHMH 16 Rev 6/95

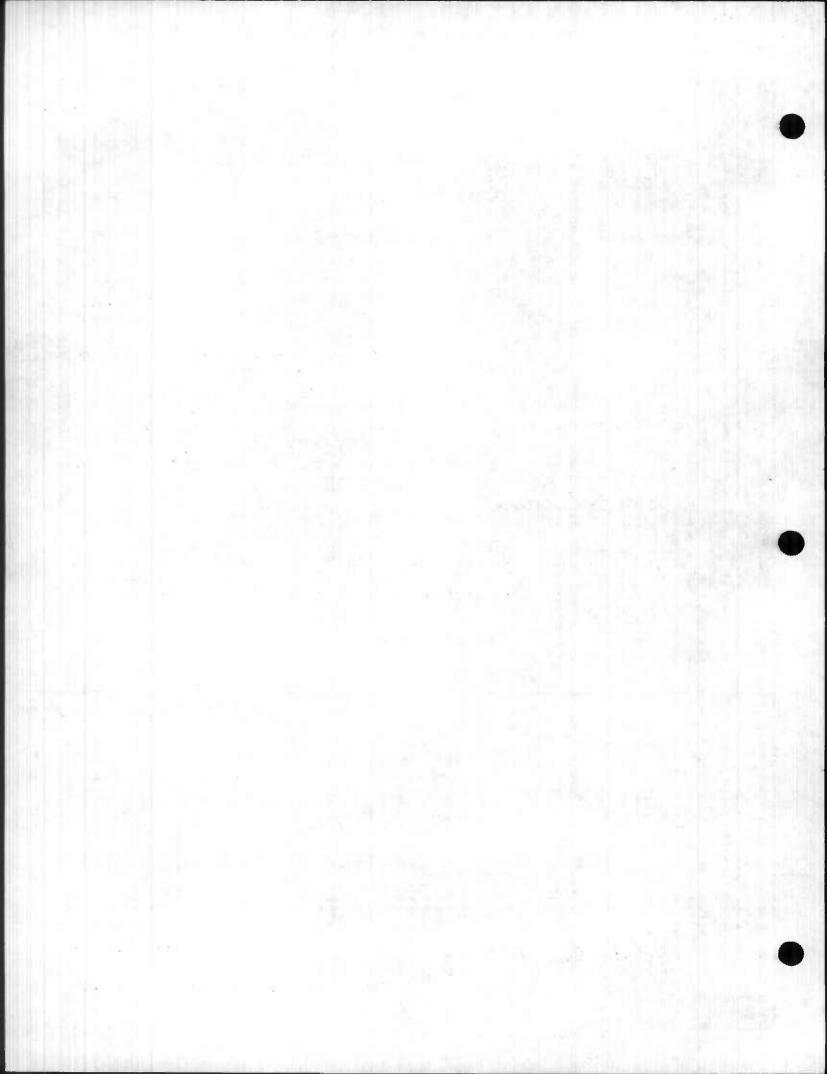
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State of Maryland / Department of Health and Mental Hygiene

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/Medical	M	Marjorie Lynn Fi	isher							Decemb			2:4	7 A.M.
Examiner	4e F	acility Name (If not institution, git	ve street end number	er)				4b. City, To	wn, or Loc	cation of Deat	4c. Cou	nty of Deeth		
		Union Hospital						E	lkton	l	C	ecil		
Funeral	5. Sc		Sax 7 1 □ M 2 🖾 F	Age (In yrs.	lest birthdey)	If Under Months	r 1 Yaar Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, De	th y, Year)	9. Birth	pleca (Si	ete or Foreign
Director		2-84-5983 al Residence of Decedent	тым гдіг	36	Yrs.					June 9,				rolina
/land	10a.	Stete 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Insi	da City Limits
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Departmen mportant: any injury ance.	21.5	Signature of Funeral Section 1009	190	2				ess of Fecilit		107.6				
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ling physician and ie as the burial-transit	Ceu	uentially list conditions, ry, leading to immediate se. Enter Underlying se (Disease or injury initiated events ulting In death) Lest	o. Henry	Due to (or as a conse		P	Meky	resto	wel.	Llenn	loca		
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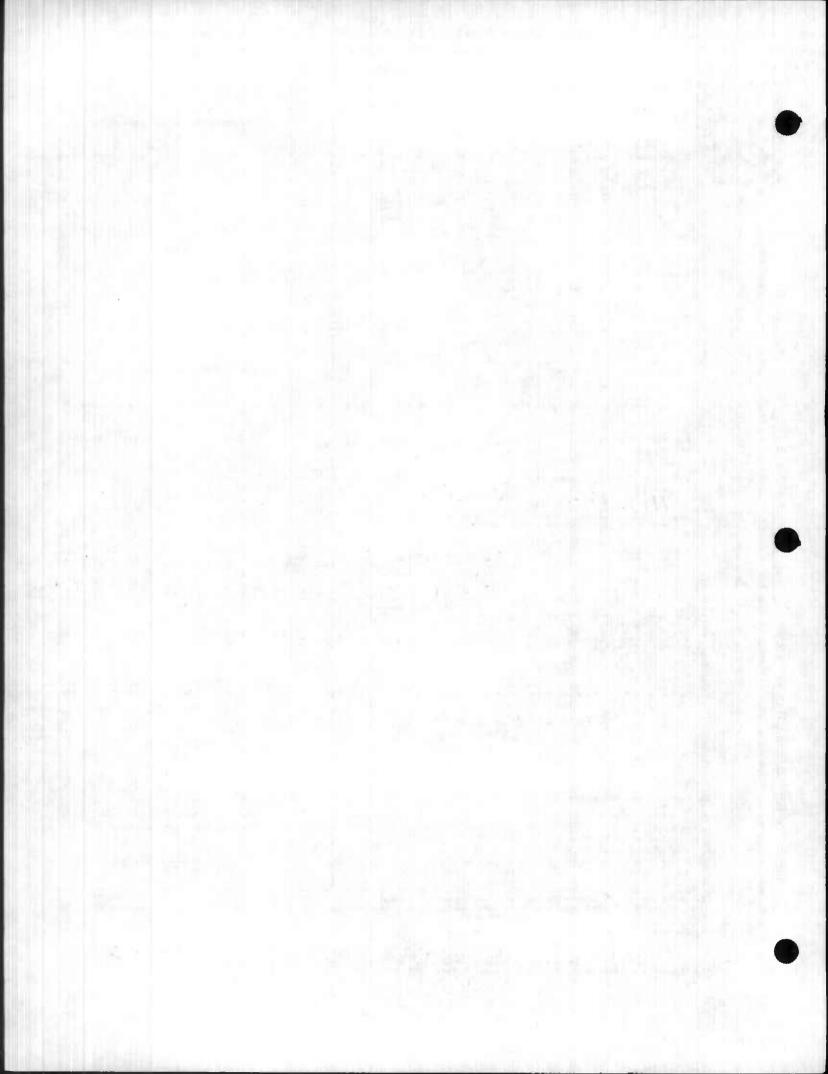
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Physician 21,2000 Edward December Bromwell Freeman 10:25am /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner William Hill Health Care Talbot Hours Min. 8. Date of Birth (Month, Dey, Year) OCT 8, 1904 If Under 1 Year 5. Sociel Security Number Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Deys Months 10km 20 F 96 MD Director 212-03-0839 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1☐Yes 2☐ No Director TALBOT EASTON 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò Негле 23а 501 DUTCHMANS LANE Funeral 21601 death IISA 14. Race - American Indien. 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter of Depertment of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examples. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: WHITE by 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) STOCK BROKER INVESTMENT 17. Father's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumeme) JOHN WILLIAM FREEMAN MARGARET BROMWELL 19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) C.ELLIOTT WHEELER/EST.PER. REP. PO BOX 1209 EASTON, MD 21601 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremetion 3 □ Removel from State OXFORD CEMETERY 4 ☐ Donetlon 5 ☐ Other (Specify) 1-03-01 OXFORD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA ewnom 200 S. HARRISON ST EASTON, MD 21601 23e. Pert1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line. Approximate Intervel Between Onsat end Daath **Physician** /Medical Immediata Causa (Finel disaasa or condition resulting in deeth) Examiner Examiner siclan end buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Diseasa or injury that initiated events resulting in death) Lest attending physician Box 68760 edicai the Due to (or es e consequença of) Physician/M Division of Vital Records, P.O. Part II. Other significant conditions contributing to death by not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 6 1 Yes 2 No 3 Probably 4 Unknown ð 90 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed A No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Wes case raferred to medical examiner? Be 26. Placa of Death (Check only ona) Hospitet: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 1 Yes 2 No Othar: Nursing Home 5 Rasidenca 6 Other (Specify) 2 this 28c. Injury at Work? 27. Manner of Deeth 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 1 Naturel 5 Pending s after deeth. 1 Yes 2 No investigation 2 Accidant 6 Could not be datamined 281. Location (Streat end Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral D (Certifying Physician: To the best of my knowledga, daeth occurred et tha tima, date and place, end dua to the ceuse(s) end menner as stated. edicai 29a. Certifie 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end mennar steted. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name end eddress of person who complated cause of death stem 23e) (Type, Print) M.D WILLIAM H. WOOD, JR. 505 DUTCHMANS LANE EASTON, MD 21601

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 424 6 Certificate of Death 2. Data of Deeth 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death DECEMBER Day 6.50 AM 18,2000 Frederick L. Frost, Jr. 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Nama (If not institution, giva street and number) Anne Arundel North Arundel Hospital Glen Burnie, MD 7. Age (In yrs. last birthday) If Undar 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 1 M 2□ F 68 Yrs. 06-16-1932 578-42-4257 Washington, DC Usual Rasidance of Decedant 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 X No Washington 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 1926 D Street, N.E. 20002 U.S.A. Race - Amaricen Indian, Black, Whita, atc. 12. Was Dacedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) Never Married 2☐ Married 1 Yes 2 No 1 Yas 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) 12th Contractor Self-Employed 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Name (First, Middla, Last) Frederick Frost Sr. Annie Coats 19b. Mailing Addrass (Straet and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Doris Frost - Sister 1926 D Street, N.E. Washington, D.C. 20002 20b. Plece of Disposition (Name of cematary, cramatory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata Lincoln Memorial Cemetery 12-21-00 1 A Burial 2 Cramation 3 Ramoval from Stata Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Bacon Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensaa BACon_CC036/3447 14th Street, NW Washington, D.C. 20010 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heer failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Daeth Immediate Causa (Final disaasa or condition resulting in death) SEPSIS ACUTE REWAL FAILURE Due to (or as a consaquance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of ceusa of daath? 24a. Wes an autopsy performed?

Physician /Medical Examiner

that the death cartificate be axecuted

Box 68760,

P.O. 1

Records,

of Vital

Division

Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifica

To the Hospital or A within 24 hours after To the Funerel Direcompletaly filled in b

2

Be

Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23a or 28a-f show the Medical Exercises must be notified at

2 should be filed within 72 and Mental Hygiena. s marked other than "na

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other treumatic event,

21215-0020

Maryland

Baltimore,

Director

Funeral

p

Completed

Physician/Medical Examiner attanding physician and for use as the burial-transit Sequantially list conditions, if any, laading to immadiata ceusa. Enter Underlying Ceuse (Disease or injury that initiated evants rasulting in death) Last þ Completed

25. Was cesa rafarred to medical 1 Yas 2 No 27. Menner of Daeth 1 Natural 5 Panding

2 Accidant

investigation

Hospital: 12 Impatient 2 ER/Outpatient 3 DOA 28b. Tima of Injury

26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify)

28d. Dascribe how injury occurred 1 ☐ Yas 2 ☐ No

6 Could not be datermined 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 12 Certifying Physician: To the best of my knowladge, death occurred at tha tima, data and place, end dua to tha ceusa(s) end menner es steted.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Cartifies

28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata)

1 Yes 2 No

29b. Signatura and titla of certifian

29c. Licansa number 051245

29d. Data signad (Month, Day, Year) DECEMBER 18,2000

1 Yas 2 No

30. Nama end eddrass of person who complated causa of daeth (Itam 23a) (Type, Print)

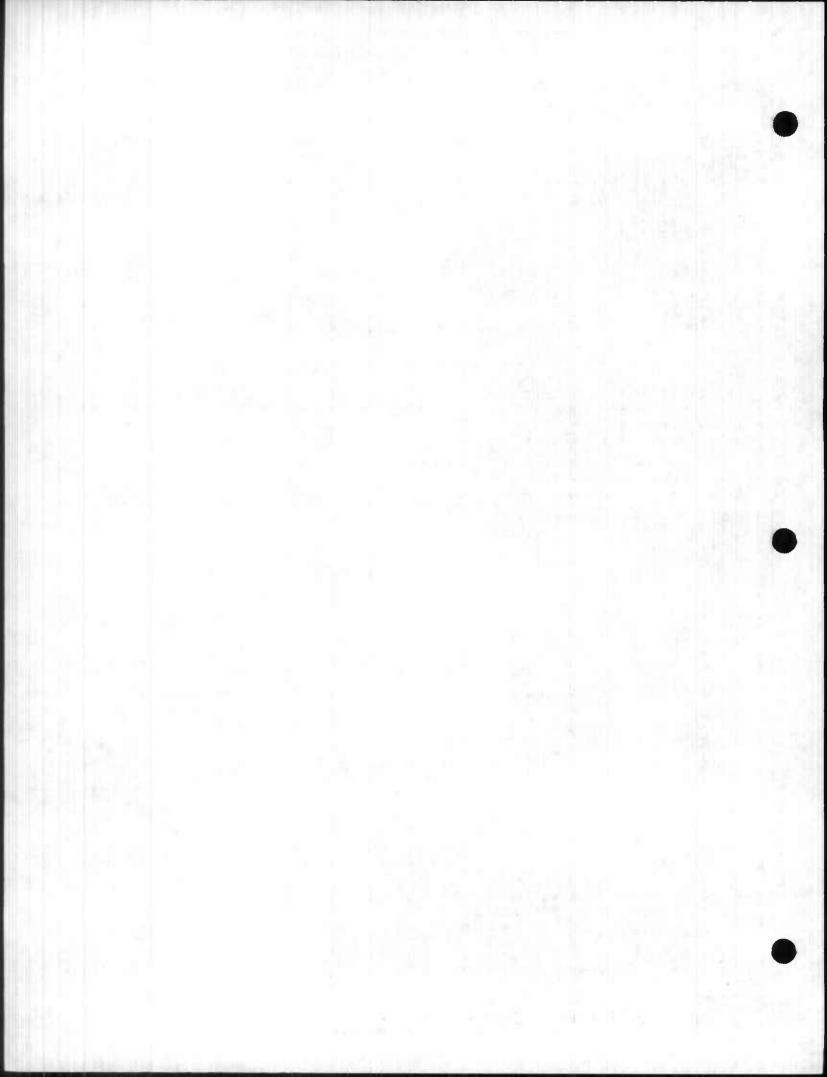
SHARIF 31. Data filad (Month, Day, Year) DEC 2 0 2000

HARBOR HOSPITAL CTR-301 hospital drive. Glen Burnie -32. Registrar's Signatura

G. Sparks

Registrar

MD



en 1 per n	nd G791 1/4/01 yf 1. Decedent's Name (First, Middle, Last)	Certificate of Dea	2. Date of De	Reg. No.	3. Time of Dea	
Physician /Medical	Freeman , John Edward John Edward		Met. 2	26,2000	Year 1616	
Examiner	4e Fecility Name (If not institution, give street and number) The Kent & Queen Annes Hospital In		y, Town, or Location of Deat stertown	4c. County Kent	of Death	
Funeral Director	5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birth 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	hdey) If Under 1 Year If Under 1 Year Months Days Hou	nder 24 Hrs. 8. Date of Bir (Month, Date 8 – 29/1	th ay, Year) 1939	9. Birthplece (State or For Country) Maryland	
,	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Legation			10d. Inside City Li	
short at		Hall			1 ☐ Yes 2 🖺	
be notified at Director				10g. Citizen of W		
_ 43 64	10e. Street and Number	10f. Zip Code		20100		
must must	22036 Martin Wagner Road 11. Meritet Status 12. Wes Decedent Ever in U.S.	21661	c Origin? (Specify Yes or No	U.S.A.	e - American Indian,	
or, or hame 23s cominer must by Funeral	1 Never Merried 2 Married 1 Never Merried 2 Married 3 Widowed 4 Divorced 1 Yes, Give Yeer or Detes:	13. Was Decedent of Hispani If Yes, specify Cuben, Me 1 ☐ Yes 2⊠ No Spe	xican, Puerto Rican, etc.) acity:	o Rican, etc.) Black, White, etc. Specify: Black		
	15 Decedent's Education 16a.	Decedent's Usual Occupation		16b. Kind of Bu	siness/Industry	
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the the	9th	Waterman		Seafood	l Industry	
188 0	17. Father's Name (First, Middle, Last)	18. N	Nother's Name (First, Middle	, Maiden Sumam	Θ)	
Alemba fices	Ralph Freeman	Service A. P. Service	Sophia Graves	3		
bus		Mailing Address (Street end N				
M. Tre	Sarah Caulk - Sister 23	624 Handy Pt.	Rd., Chestert	own, MD	21620	
lant: If Nam Jury or othe	1 Li Bunel 2 Cremation 3 Li Hemoval from State	Disposition (Name of v. crematory or other place) remation Servi	Dete 11-2-00		City or Town, State Delaware	
	21. Signature of Funeral Service Licensee	22. Name and Address of F		Porkine	Funeral Ser	
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T digi	27 war of Death turat 5 Pending (Month, Day Year) 28b. T			how injury occur		
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n 24 hou ne Funer pletely fill edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, whedlest Examiner: On the basis of examination and end menner stated.			, date and place,	and due to the cause(s)	
To the com	29b. Signature and title of centifier	29c. License num	51786	29d. Date signe	d (Month, Day, Year)	
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U AMENDED ITEM#26 per verbal G792 01-5-01 SS Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month **Physician** er 10:30 AM December 9, 2000 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner 1122 Chesapeake Drive Havre de Grace Harford H Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 79 Yrs. If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 5. Social Security Number **Funeral** Days 1□M 2\F 214-20-4594 September 28, 1921 Director W. Virginia Usual Rasidence of Decedent the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County 28a-f ahow the Medical Examiner must be notified at to Yas 2 No Directo Havre de Grace Maryland Harford 10e. Street and Number 10f, Zip Coda 10g. Citizen of What Country? 8 21078 238 1122 Chesapeake Drive USA Funeral 14. Race - Amaricen Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) or Heme 11. Marital Status 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1 Yas 2 No Specify: à 3√Widowed 4 □ Divorced White Yaar or Datas: "natural". Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry then Elementary/Secondary (0-12) Collega (1-4or 5+) Civil Service U.S. Government 12 other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) permit. Pages 1 and 2 should be t Department of Health and Mental Infrportant: If Nem 27 is marked oth any Injury or other Be 2 should be fi and Mental I Elijah Monroe Hunt Alice Summerfield 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) William Frye (son) 149 Bloomsbury Avenue, Havre de Grace, MD 21078 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Data 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) Harford Memorial Gardens 12/12/00 Aberdeen, Maryland 21. Signature of Funaral Sarvice Licenses 72. Name and Addrass of Facility Tarring-Cargo Funeral Home, P.A. 23a. Parl . Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Aberdeen, Maryland 21001-3399 Approximata tntarval Batween Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Physician/M Parl II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? E 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Wara autopsy findings 24a. Was an autopsy Completed avaitable prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 No Be 25. Was cesa refarred to medicel axaminar? 26. Placa of Death (Check only ona) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 0 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: 5 Pending 1 ☐ Yas 2 ☐ No death. 2 Accident invastigation or Attend after deat Director: 6 Could not be 3 ☐ Suicide 28a. Place of tnjury - At homa, farm, streat, factory, offica building, atc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital within 24 hours a To the Funeral D briffying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

Icat Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar stated. 29a. Certified Medicai

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29th Signat

Registrar's Signatura

complated causa of death (Itam 23a) (Type, Print)

29c. Licensa number

29d. Data signed (Monthly Day, Year)

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Registra

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Procedured Recommend of Procedured Section (1997) Bayside Care Center Formed Directories For					State of Maryland		tificate of			ig. No.	*7	6413
Mary Fally News (mail intelligence para personal company) December 21, 2000 4:00 AM				1. Decedent's Neme (First, Middle, Last)					2. Dete of Deat	n	Vaar	3. Time of Death
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Charles

Louise M. Morgan (Dau,

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State of Maryland /	Depa	rtment	of H	ealth	and	Mental	Hygiene	

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	Discontinuit		1. Decedent's Nama (First, Middla, Li	ist)	747				2. Deta of Dee Month	th Day	Year	3. Time of Deeth
	Physicia /Medic		Benedict	Joseph		Gree	enwell			9, 2000		2:57 AM
	Examin		4a Facility Neme (If not institution, gi						Location of Deeth	4c. County		
			LEONARDTOWN ROAD				Williams & Van	HUGHESV		CHAF		
	Funeral Director			11X M 2 T F	e (In yrs. la	ast birthday) Yrs.	If Under 1 Yea Months Dey			, Year)	Coun	
	show the w		10a. Stete 10b. County		10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	fier death with the Marylen ritems 23s or 28s-f show first mast be northed at	X 1	Maryland St. 1	Mary's	L	exingt	on Park			10g. Citizen of \	Whet Coun	1 ☐ Yas 2½ No try?
	23a It		45865 Pine Road					20653		US	Α	
9	72 hours after death with the Maryland natural, or Heme 23e or 28e-f show pical Examiner must be norified at	Funeral	11. Meritel Stetus 1 ☐ Navar Marriad 2 ☑ Married	12. Wes Decedant I Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	196	4	Was Decedent of f Yes, specify Cu 1 ☐ Yas 2 ☐ No	Hispanic Origin? (Suban, Mexican, Puar o Specify:	Specify Yas or No- to Rican, etc.)	14. Rac Blee	ck, White,	
Š	Irel',	db	3 Widowed 4 Divorced	Yeer or Detes:	196	7	A					
Baltimore, Maryland 21215-0036	within 72 hours iene. then *neturel', or Heoles Ex	Completed	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12)	ducation ada completed) College (1-4or 5	i+)	(Give	DO NOT use retii	e during most of wo red)	orking	16b. Kind of B		
7 0	ETE	Be Co	12th Grade 17. Fathar's Name (First, Middla, Las)		Lic	uor Sto	re Owner 18. Mother's Na	me (First, Middle,	Retail Maiden Sumen		S
lar		0	James Com	bs G	reenw	ell		Mary	Gene	vieve		Norris
ary	E E E		19e. Informent's Neme/Relationship	(Type, Print)	0	19b. Meilir	ng Address (Street	et and Number or R	ural Route Numbe	r, City or Town,	Stete, Zip	Code)
Ξ	1 end 2 Heelth e am 27 is ther tra		Pamela I. Greenw	ell (Spouse	e)	45865	Pine Ro	ad, Lexin	gton Par	k, Mary	land	20653
more	of it		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		St.	eca of Dispo ametery, cren Franc	sition (Neme of netory or other p cis Xavi	Cemetery er	Dete 2/18/2000	20c. Location - Compt	City or To	wn, Stete faryland
Rail	Department Department Important: any Injury o		21. Signatura Fuperal Service Ligar	sfield, r	1	D1	rinsilea	I Funeral	nome, P	.A.		
F	hysician		23e. Pert1. Enter the diseese, or conshock, or haart failure. List only	one cause on each lir	10.	. Do not ent	er the mode of d	ying, such es cardia	c or respiratory er	rest,	1	Approximete Intervel Between Onset and Death
!	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth)	· Mun		es e consec	uence of):					
-	2 ts	l le		h							i	
Ö,	ate be executed thysician end the burial-transit	i Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury		Due to (or	es e conseq	uence of):					
(68/60,	phy:	Medicai	thet initieted events resulting in deeth) Lest		Due to (or	es e conseq	uence of):					
	the attending p	Physician/M	Pert II. Other significant conditions	contributing to death bu	ut not resu	Iting in the u	nderlying cause (given in Pert I.	23b. Dld t	obacco use ço	ntributa to	the cause of death?
7	5 8 0	by Phy			-				101	708 20 No	3 🗆 Prol	oably 4 Unknow
ecord	e law requires has been sign je 2 should be	Completed b							24a. Wes	en eutopsy med?	av	are autopsy findings aileble prior to mpletion of cause deeth?
=	ete ha	Co							164	'es 2□No	18	Yes 2□ No
VITAI	entific ector	Be	25. Wes case referred to medical examiner?	11					eth (Check only o	ne)		
6	Pis di	2	1 XYes 2 No	Hospitel: 1 Inpatie			I SLI DOA		Home 5 Resid			- A
	the the	on	27. Menner of Deeth 1 ☐ Naturel 5 ☐ Pending	28e. Dete of Injur (Month, De)	Year)	28b. Time of Injury	W	lork?	Davien			AND EIXEDORY
200	Attending r death. ector: Afte by the fune	Cat	2 Accident investigetion 3 Suicide 6 Could not l	12- 7-6		2:19 F					1	I Route Number,
5	or Attend efter death Director: / d in by the	ertification:	4 ☐ Homicide determined	building, etc			oot, lootory, oilic		City or Tou	m, Stete)		
	4 hours 4 hours Funeral tely filled	edical C		hysician: To the best ominer: On the besis of	examineti	vledge, deett			e, end due to the	ceuse(s) end m	enner es s	ated.
	within 2 To the comple	ĕ -	29b. Signature end title of cartifier	end manner ste	neu.		29c. Lica	nsa number		29d. Date signe	ed (Month.	Dey, Year)
- 1	- ≥ - 6			. 1.			W					1 - 1 - E

29c. Licansa number O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

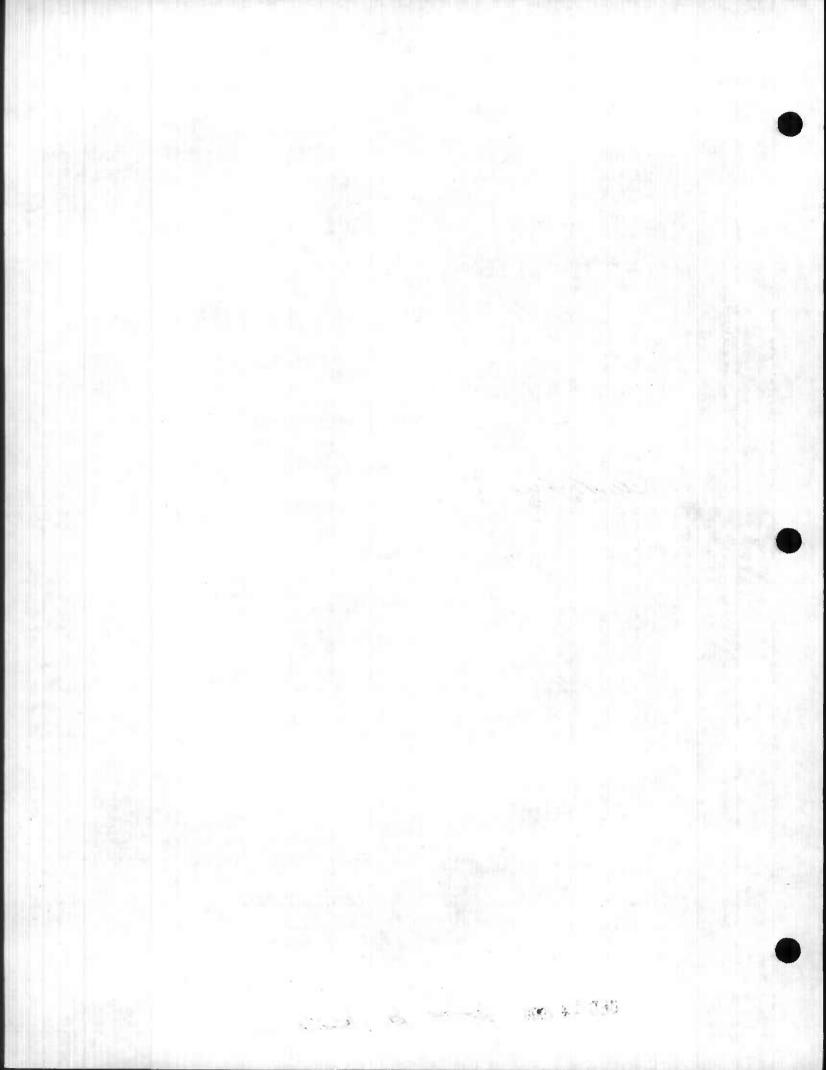
29d. Date signed (Month, Dey, Year) DEC. 9, 2000

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signetura

Registrar DHMH 16 Rev 6/95

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. 1	No.	
Physician /Medical	1. Decedent's Name (First, Middle, Last) ANECIA M. GRAY	2. Date of Deeth Month	Day Year 14. 2000	3. Time of Death 2215
Examiner	PENINSULA REGIONAL MEDICAL CENTER 4b. City, Town, or L. SALISBU		4c. County of Deeth	
Funeral Director	5. Social Security Number 6. Sex 1 Months 7. Age (In yrs. last birthdey) 6. Sex Yrs. 1 Months 1 Gey 1 Funder 1 Yeer Months 1 Deys 1 Flours Min. 1 Usual Residence of Decedent	8. Date of Birth (Month, Dey, Yes 3-26-	9. Birthpi Count	plece (State or Foreign try) DE.
pun au	10e. State 10b. County 10c. City, Town or Location		10	0d. Inside City Limits
Many Many stor	MD. WICOMICO SALISBURY			1 Yes 2□ No
with the Ma s or 28s-f s be notified Director	10e. Street end Number 10f. Zip Code	10g. (Citizen of What Coun	try?
ath w	1136- BRYN MAWR DR. 21801		USF	7
Maryland 21215-0020 d 2 should be filed within 72 hours after death v his and Mertal Hygiers 17 hours after death v 7 his marked other than "natural", or leans 234 traumstic event, the Medical Examiner must To Be Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	pecify Yes or No- p Rican, etc.)	14. Race - America Black, White, of Specify: B	
1 21215-002 led within 72 hours yegiene "natural", we than "natural", to the Medical East Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b.	. Kind of Business/Ind	Justry
T21	Elemantary/Secondary (0-12) Collega (1-4or 5+)		101 11.10	
d 2 Hygie Hyrie	8 HOUSEWIFE 17. Fether's Name (First, Middle, Last) 18. Mother's Nam	ne (First, Middle, Maid	IN KNDU den Sumeme)	72
yland yland Mental H mrked oth affo even		ROBERT	1.1	2/15
Aaryl 2 shoul and Maryl is many is many included to the contract to the contra	19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Run			Code)
	ALICE R. DENNIS - DAUGHTER 1136-BRYNMAWR DR. S	SALISBURY	1. MD 21	1801
OT CONTRACTOR	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date 20c	Location - City or To	wn, Stete
TT 1 1 1 1 2 2	Donallo 5 Other (Specify) WTNEBO CHURCH CEMETARY	12/20/2000	Colum	BIA, DE.
Salt Salt Salt Salt Salt Salt Salt Salt	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	BENNIE SI	NITH FIH	
m gozza	917-W. ISABELLAS	T. SAUSB	WRY, MO.	21801
m	23e. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac shock, or heert failure. List only one cause on each line.	or respiretory arrest,	P	Approximate Intarvel Between Onset end Deeth
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e Atturce lend condition Dua to (or as a consequence of):	sculen	discore	
21 6- 444 68760, licate be executed physicien and s the bunal-transit edical Examiner	b		İ	
68760, rifficate be executed to physician and est the burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury c.			
68760, filtrate be e. g physicien es the buria	Cause (Disease or injury that initiated events Due to (or es a consequence of):		1	
	resulting in death) Last			
S, P.O. Box ss thet the death certified by the attending be detected for use a by Physician/M	d			
O. E. D. E. D. E. D. E. D. E. C.	Part II. Other eignificant conditions contributing to death but not resulting in the undartying causa givan in Part I.	23b. Did tobac	cco uee contribute to	the causa of death?
P.O. thet the detected detected y Physic	Reval failure	1 Yes	2 No 3 Prol	bably 4 Hriknow
cord require should should		24a. Wes en et performed	1? ev	era autopsy findings eileble prior to impletion of ceuse
The law tate has begge 2 si		1 ☐ Yes		déath? □ Yes 2□ No
		ath (Check only one)	26 NO 1L	1105 2010
	examiner? Hospital: Other:	lome 5 Residence	e 6 ☐Other (Specif	fy)
C A E E E	27. Manner of Deeth 28e. Data of Injury 28b. Time of 28c. Injury at	28d. Describe how in		
Vision Attending I refeeth. Sector: After by the fune filcation	2 Accident investigation M 1 Yes 2 No			
i sage	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Strae) City or Town, St	t end Number or Rura itete)	il Routa Number,
To the Hospital within 24 hours to the Funeral is completely filled	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occur			
thin 2 the 8 mplet within 2 the 8 mplet	one) and mannar stated. 29b. Signature and time of cedifier 29c. License number	29d	Date signed (Month,	Dey, Year)
- F 3 F 8	125674		501-6113	
You		nry, V		
/ 11	7,	ny, N	14.518	09
State	31. Dete filed (Month, Dey, Year) 2000 32. Registrar's Signature G. Angeld			

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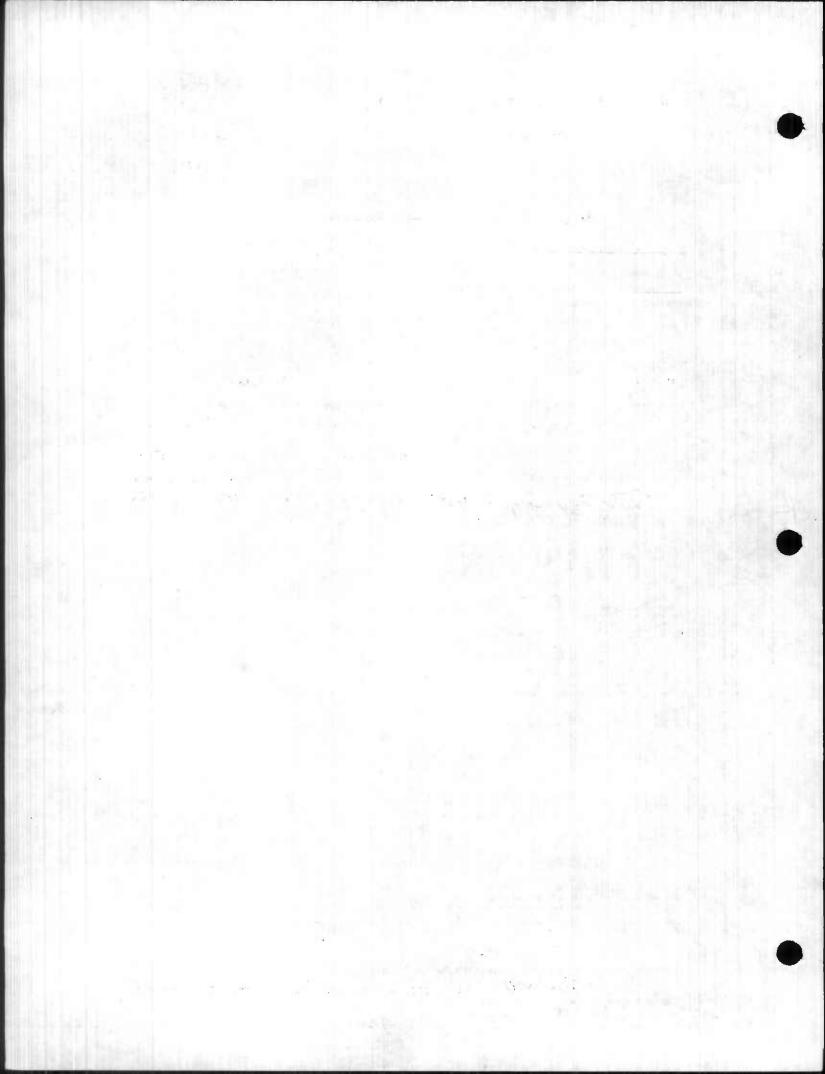
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DHMH 16 Rev 6/95

Registrar



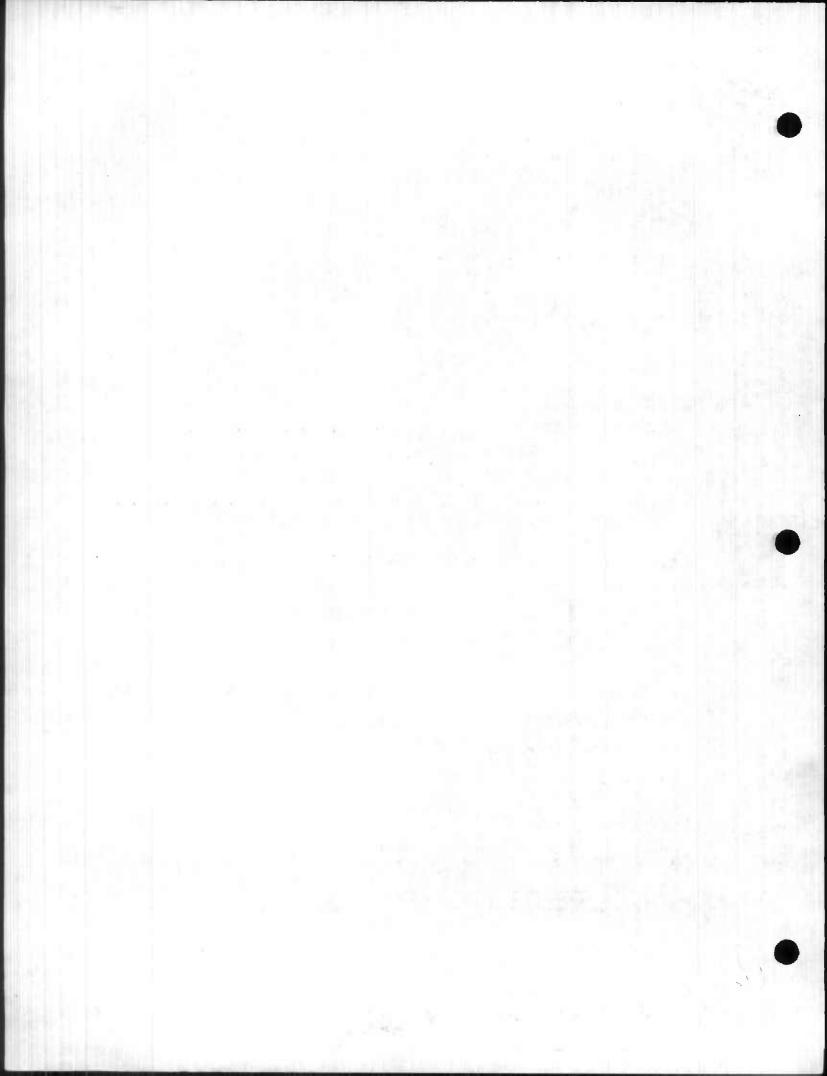
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State

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of Maryland / Department of Health and Mental Hygiene	Li	2	4	6	Ü
Cartificate of Death					

1□ M 2□ F	pital in yrs. lest birthdey)		ib. City, Town,	De o	ember Deeth 4c	Ye 17 20	000 6	ne of Death : 00AM	
give street end number) Adventist Hos 6. Sex 1 M 2 F	-			De cor Location o	ember Deeth 4c	17 20	000 6	:00AM	
Adventist Hos	-					. County of E	Death		
1□ M 2□ F	n yrs. lest birthdey)		Lake	ma Par			ntgomer	у	
	80 Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M	lin. 8. Dete (Mor	of Birth hth, Dey, Year) 15,	1920	Birthplace (S Country) Virgin	tate or Forei	
10a. Stete 10b. County 10c. City, Town or Location District of Columbia Was								de City Limi	
Columbia		Washi	ngton		100 Cit	10g, Citizen of What Country?			
t., N.E.		20002					State	S	
12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give A		S. 13. Was Decedent of Hispenic Origin? (Specif Yes, specify Cuban, Mexicen, Puerto R				14. Race - A Black, V	American Indi White, etc. Black		
Year or Dates:		10 105 22110	эрвину.			<i>Specity:</i>	DIACK		
s Education grade completed) College (1-4or 5+)	(Give	dent's Usuel Occup kind of work done DO NOT use retired	during most of (working	16b. K		ess/Industry		
4		Secre		1000			vernme	nt	
ast) mer		, Mitch		ue Epp	Middle, Maiden	Sumeme)	11/6		
ip (Type, Print)	19b. Maili	ng Address (Street	and Number or	Rurel Route	Number, City	or Town, Sta	ate, Zip Code)		
Sister		Jay St.	, N.E.						
3 Removal from Stete		netory or other place		Date			y or Town, Sta		
ecity)		coln Cem	-	12/23	/2000	Bren	twood,	MD	
21. Signifure of Funeral Service Licensee 22. Name and Address of Fecility Stewart Funeral Home									
I shows		4001 Be:	nning R	d., N.	E. Wash	n., D.	C. 20	019	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of):									
d									
ne contributing to death but not for the contribution of the contr		nderlying ceuse giv	en in Part I.	23	b. Did tobacco		buta to the cr		
Me11,74	r			24	a. Was an auto performed?	opsy 2	24b. Were autaveilable completic of death?		
en vien					1 ☐ Yes 2	No	1 🗆 Yes	2□ No	
			26. Place of	Death (Chec	k only one)				
Hospital: 1 Inpatient	a ER/Outpatie		4 C Nuisin		Residence				
28e. Date of tnjury (Month, Dey Y	ear) 28b. Time o	Wor	yat rk? Yes 2 □ No	28d. De	scribe how inju	iry occurred			
27. Manner of Deeth 1 Natural 2 Accident 3 Suicide 4 Homicide 28. Date of Injury 28b. Time of Injury 4 North, Dey Year) 28b. Time of Injury 4 North, Dey Year) 28b. Time of Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 28c. Date of Injury at Work? 28d. Describe how injury occurred									
xaminer: On the besis of ex	amination end/or in							use(s)	
0	40			2					
alleline	30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Part 1 2 1/22 Meth 4202 (2) certifying Ped 1446 + Ruille PMD 2038/								
the completed cause of deet	h (Item 23a) (Type,	ens bune	, Rd A	4447	*Uille	, mo	20 19		
	xaminer: On the besis of ex	xaminer: On the besis of examination end/or in and manner stated.	xaminer: On the besis of examination end/or investigation, in my or and manner stated. 29c. Licens	xaminer: On the besis of examination end/or investigation, in my opinion, death of and manner stated. 29c. License number	examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the and manner stated. 29c. License number	examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date an and manner stated. 29c. License number 29d. Die	xaminer: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end and manner stated. 29c. License number 29d. Date signed (i	29c. License number 29d. Date signed (Month, Dey, Y. DECEMBER 17,	

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State of Maryland / Department of Health and Mental Hygiene 1 4 2 4 2 4

					Cer	tificate of	Death		Reg. No.			
		1. Decedant's Nama (First, M.	ddla, Last)					2. Date of De Month	ath Dav	Yaar	3. Time	e of Death
	Physician /Medical	Orville L	eRoy Greynol	lds				DECEMBE		000	07:0	3 P.M.
	Examiner	4a Facility Name (If not institu	tion, giva street and num	ber)			4b. City, Town, or	Location of Deatl	4c. County	of Death		
		MALCOLM GROW	MEDICAL CENT	CER			CAMP SPR	INGS	PRINC	E GEO	RGE'	S
	uneral irector	5. Social Security Number 292 24 1030	6. Sex XX M 2□ F	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da July 29	y, Year) 1931	9. Birthpli Count West	aca (Sta in) Viro	te o <i>r Foreig</i> n ginia
puel	M III	Usual Residence of Decedent 10a. State 10b. Cou		10c. City	, Town or Loc	cation				10	Od. Inside	e City Limits
Many	to to	Maryland Pri	nce George's	c1	inton						1 🗆 Y	as 20No
the	7.28s	10e. Street and Number		0	2.001.	10f. Zip Code			10g. Citizen of \	What Count	try?	21
N.	S S	5902 Wolverto	n Lane			20	735	Mary I	United	Stat	es	
aryland 21215-0020 should be filed within 72 hours efter deeth with the Maryland	Important: if hem 27 is marked other than "natural", or heme 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Nover Married 3 Divor	12. Was Deced Armed Force Married Y Yes 2 If Yes, Give ed Year or Dal	00 195 No 195	2 1	Vas Decedent of I Yes, specify Cub	dispanic Orlgin? (Sean, Mexican, Puerl Specify:	pecify Yes or No to Rican, atc.)	14. Rad Blac Specify	e - Amarica ck, White, e	etc.	1,
5-0020	Pare P		dent's Education	tas: 1.37		ent's Usual Occu	nation		16b. Kind of B			
2 2	rked other than naturalities seent, the Medical To Be Completed	(Specify only high	hast grade completed)		(Give I	kind of work done OO NOT use retire	duning most of wo	rking	TOD. PAING OF D	2311033/110	lustry	
2121 d within	that do	Etementary/Secondary (0-1	2) College (1-	4or 5+)	Consu				Telecom	munic	atic	ons
0 21	The C	12 17. Fathar's Nama (First, Midd	fla, Last)				18. Mother's Na	me (First, Middla			0.020	
ld be	o so	Joseph Orvill	e Greynolds				Zola Vi	rginia E	'ox			
Z 2 5	27 is marked other than r traumatic avent, the Mr. To Be Comp	19e. Informant's Neme/Relati Patricia Ann		VIFE)			and Number or Ri				Code)	
s 1 and	ette ette	20a. Method of Disposition		20b. Pl	ace of Dispos	sition (Name of	, Clinto Ga) Jan 25	.20001	20c. Location	City or To	wn, State	1
altimore, mit. Peges 1 er	tant: If	Burial 2 Cremati	(Specify)	10110	ington	Mationa	1 Comete	Y*17	Arlingt	on, V		
Bait permit.	any ir	21. Signature of Funeral Serv	Licansee		Al	Nama and Address	ess of Facility Lee Ferry R	Funeral	Home,	Inc 6	633 ad 20	01d 0735
Dhu	.o.iolon	23a. Part1. Enter the disease shock, or heart failure.	, or complications that ca list only one cause on ea	used the death ch line.	. Do not ente	er the mode of dyi	ng, such as cardia	c or raspiratory a	rrest,			mate Between and Daath
	rsician ledical	Immadiata Causa (Final								7.73	1111101	
Exa	aminer	disease or condition resulting in death)	a. PULMO	NARY EM	as a consequence	nence off.				IUI	NKNO	WIN
	je literal		MVOCA							TIN	TTENTO	CTAT
petno	ensit	Sequentially list conditions	b. MIOCA.	RDIAL I	as a consequ					Ur	NKNO	NIN
0,0	EX EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	PIII.MO	NARY FI						TIN	NKNO	GIN
. Box 68760, death certificate be executed	g physician and es the buriel-transit	that initiated events	С. ТОТЖТО		as a consequ					Ur	NKINOI	NIN
diffice	010	resulting in death) Last								İ		
XO E	for use		d									
death	ed for	Part It. Other significant cond	littons contributing to dea	ath but not resu	Iting In tha un	derlying cause gi	ven in Part I.	23b. Did	tobacco use co	ntributa to	the cau	se of death?
P.O.	signed by the attendi			11.				108	Yes 2□ No	3 Prob	oably 4	4 🗆 Unknow
ecords,	2 should								an autopsy ormed?	ava	ailabla pr	osy findings rior to of causa
E 2	pege 2							10	Yes 2 No	10	Yes :	2 X No
_	certificate rector, per	25. Was case refarred to med	lical				26. Place of De	ath (Check only	one)			
of Vita Physician:	= 0	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	patient 2 E	R/Outpatien	t 3□ DOA Ot	her	loma 5 ☐ Rasi		er (Specify	y)	
		27. Menner of Death	28e. Dete of		28b. Time of	28c. fnju Wo		7	how injury occur			
VISION Attending	the funer the funer cation:	Z L Mooidoill	estigation	, Day Tear)	Injury		Yes 2□No					
- 25	10 E	3 ☐ Suicide 6 ☐ Col 4 ☐ Homicide det	uld not be ermined 28e. Placa of building	of fnjury - At ho g, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (City or To	Street and Numi wn, State)	ber or Rura	I Routa I	Vumber,
To the Hospital or within 24 hours er	To the Funeral Dir completely filled in Medical Cer		lying Physician: To the base and manner	sls of examineti								se(s)
To th	To the	29b. Signatura and titla of	the f	_		29c. Lican	sa number		29d. Date signe	d (Month, I	Day, Yes	er)
)		1 -	19	Ilk			-064601	-	Dec	14,	2	600
1	20/	30. Name and address	on who complified cause	of death (Item	23a) (Type, I	Print) 89 MD(G/1050 W.	PERIME'		760 /	((00	

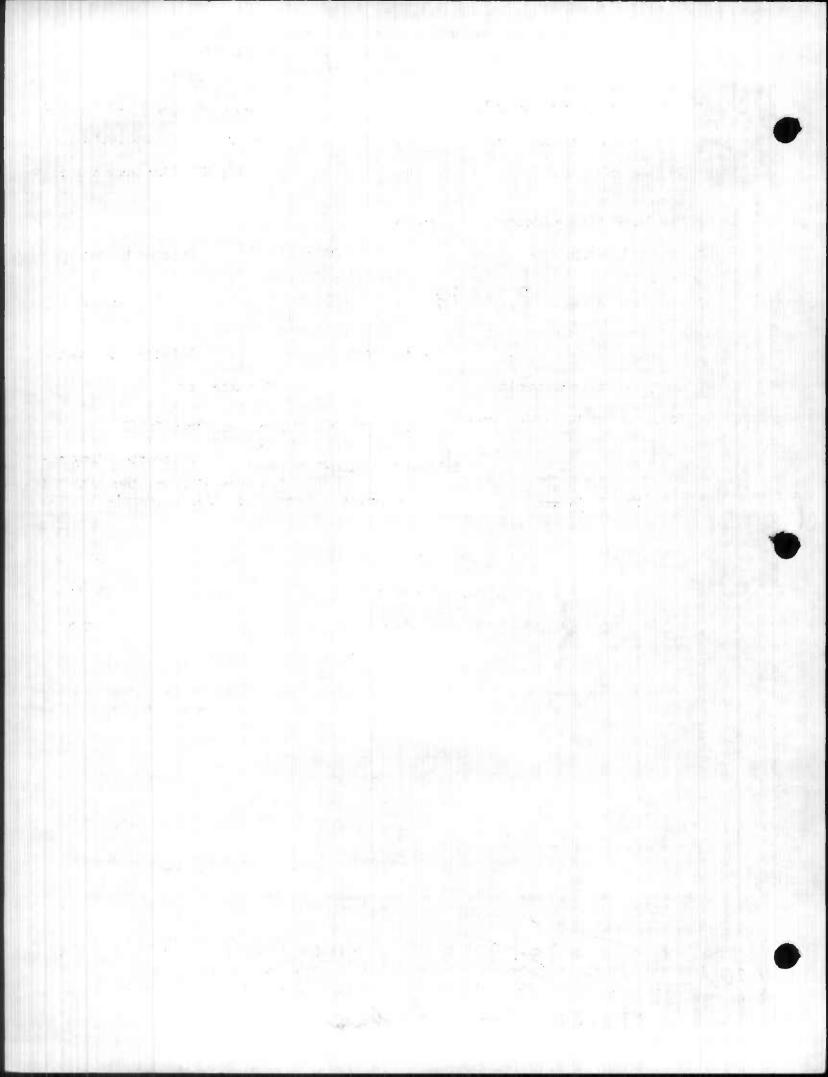
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State

Registrar

31. Date filad (Month, Day, Year)

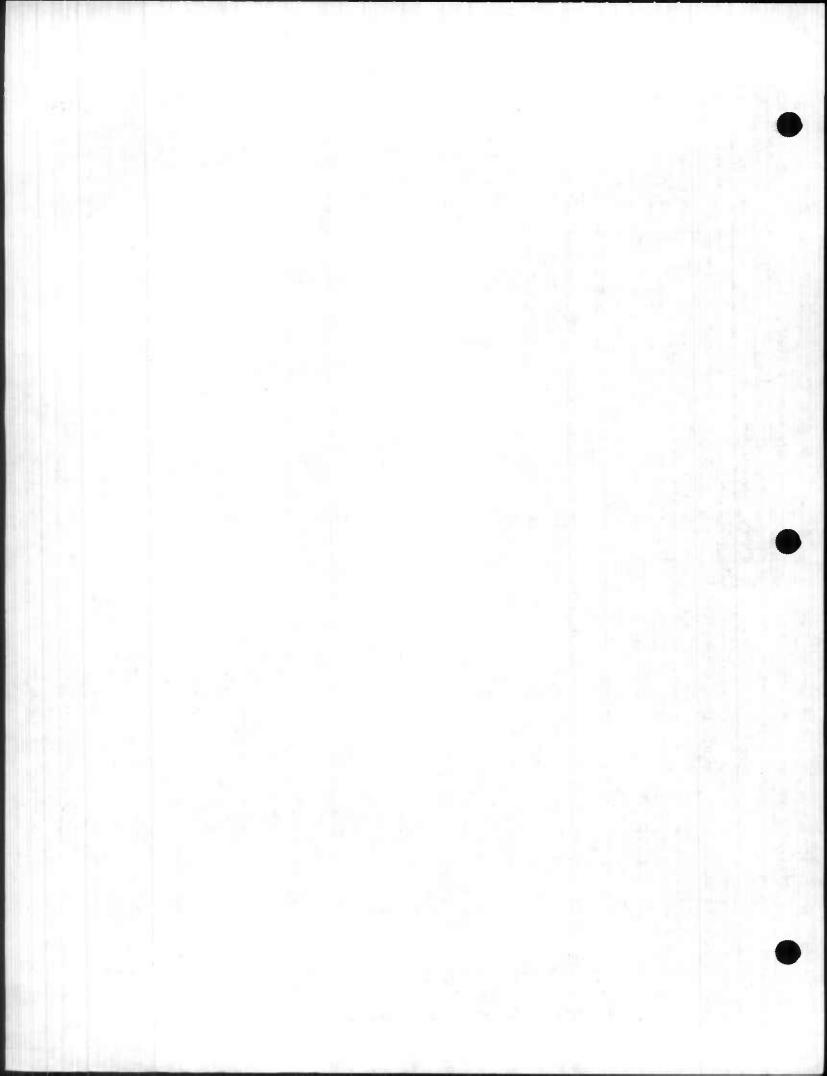
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			State of Man		artment of		nd Mental H	lygiene	46	1423
		1. Decedent's Name (First, Middle, Last)				2. Date of	Deeth	Yeer	3. Time of Deeth
	Physician /Medical	ROTELIA	GREEN				DECEN	BER 20,20	100	11:29am
	Examiner	4e Fecility Name (If not Institution, give PRINCE GEORGES C				4b. City, Tow CHEVE	n, or Location of Do RLY	PRINC		ORGES
	Funeral Director	220 20 4374	מא מות ב	n yrs. lest birthday 74 Yrs.	Months De		4 Hrs. 8. Date of (Month, 4/29)	Birth Dey, Year)		ace (State or Foreign ry) olk, VA
	or 2844 show or 2844 show be notified at	Usual Residence of Decedent 10a. State 10b. County MD Prince Ge 10a. Street and Number		Oc. City, Town or L Upper Ma:		8		10g. Citizen of W		0d. Inside City Limits 1 1 Yes 2 □ No
020	un after death v af, or flems 23s Examiner must by Fumeral	3 ☐ Widowed 4\\Divorced	npus Way Ro 12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:		Wes Decedent of Yes, specify C	of Hispenic Origi uben, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No- 14. Race Bleck	e - America k, White, e	
21215-0020	ed within 72 ho ygienn. yrgienn. r, the Medical Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Oc kind of work do DO NOT use rel	ne durina most o	of working	16b. Kind of Bu	siness/Indi	ustry
Maryland 21	Mental Hygier trived other that sevent, the	17. Fether's Neme (First, Middle, Last)	.0	Foo	od Servi	18. Mother		Priva dle, Maiden Sumam nomas		
	and 2 should be set traumed.	19e. Informent's Neme/Reletionship (7) Ernest Green So	n	1470	3 Dunwo	od Vall		mber, City or Town, Bowie, M		Code) 0721
Baltimore	Pages 1. next of He int; if Hear iry or oth	20e. Method of Disposition **MX**Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removel from Stete		metory or other	olace)	Date h 12/24	20c. Location -		wn, Stete th Carolina
Balt	permit. Departm imports any infu	21. Signature of Funeral Service Licans		T	2. Name and Ad Pope Fun	eral Ho	me			
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or corpole shock, or heart feilure. List only of Immediate Ceuse (Finel disease or condition resulting in death)	. Com	e deeth. Do not er	quenca of:	tying, such es c	ardiac or respirator	MD 2074 y errest,		Approximete Intervel Between Onset and Deeth
Box 68760,	eath certificate be executed ettending physicien end for use as the bunal-transit clan/Medical Examin	Cause (Diseese or Injury that initiated events	2 H	V	quence of): USUP QUENCE QUE	tero l	vemio			
P.O. B	that the death cered by the ettending detached for use y Physician/N	Pert II. Other significant conditions con	ntributing to death but n	not resulting In the	underlying cause	given in Pert I.		Oid tobacco use cor	3 Prob	the cause of death?
Records,	lew requires has been sign je 2 should be mpleted by						P	Ves en autopsy enformed?	eve con of d	ore autopsy findings siteble prior to mpletion of cause death?
ita	s certificate director, pag	25. Wes case referred to medical				26. Plece	of Deeth (Check or	nly one)		
ion of Vital	2 00	1 Yes 2 No 27. Menner of Deeth 1 Natural 5 Pending investigation	dospitel: 1 Inpatient 28a. Dete of Injury (Month, Day Yo	28b. Time	of 28c. t	Other: 4 Num njury at Work? I Yes 2 N	28d. Descri	lesidence 6 Other)
Division	its after death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury building, etc. (S		treet, fectory, offi	ca	28f. Location City or	on (Street and Numb Town, State)	er or Rura	l Route Number,
	in 24 hours in 24 hours he Funer pletely fil		nician: To the best of mer: On the basis of exent menner steted	amination end/or in	nvestigation, in m	y opinion, deeth		ne, date and placa, a	and due to	the cause(s)
0	Towns N	· ON/ww	uns	mD	7	onse number	3210 MERCAN	29d. Date signed	2 2	100
	(8)	NICHOLA	omplated ceuse of deat	2111	Print)	1221 LARG	MERCAN 20, MD	2077	LAN	E
	State Registrar	31. Dete filed (Month, Day, Year) DEC 2 2 2000	38. Registrar's	Signeture .	Spork	1				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 12/19/2000.BMW.Montg.Co. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** ANTHONY DAMION GREEN December 14 2000 7:20 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner VAMHCS FORT HOWARD DIVISION FORT HOWARD BALTIMORE 5. Sociel Security Number 7. Age (fn yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dev. 9. Birthplace (State or Foreign Country) Jamaica MARYLAND 6 Sex **Funeral** Monfhs 1♥ M 2□ F Days Hours Yrs. 8-10-80 Director 20 213-57-0414 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Directo MD. PRINCE GEORGES LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of Whef Counfry? ra 23a or 7812 ALLENDALE DR. 20785 U.S.A. Funeral 12. Wes Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 □ NoACTIVE
If Yes, Give
Year or Dates:

DUTY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bece - American Indian 11. Marifal Stafus Black, White, etc. 1) Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced DUTY BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12 SAILOR U.S. NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be 2 Mental 10 UNKNOWN ROSEMARIE BATTIEST 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) them 27 i ROSEMARIE LEACH/MOTHER AS ITEM #10 SAME Baltimore. GREEN, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Melhod of Disposition Date Pages 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ŏ 12/22/00 ARLINGTON, VA. ARLINGTON NAT'L. CEM. 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility 5801 CLEVELAND AVE. Chamberrail MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical PULMONARY EDEMA 14 hours Examiner Due to (or as a consequence of): Examiner ANOXIC BRAIN DAMAGE 4 months certificate be executed physicien end s the bunal-tran Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760 Physician/Medical thet initiated events resulting in death) Last Due to (or as a consequenca of): 88 980 for signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown PANHYPOPITUITARISM Records, by 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en autopsy Completed ils certificate had Y Yes 2□No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☑ No 17 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After or Attending 1 Netural
2 Accident 5 Pending Investigation 1 Yes 2 No death Director: / 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide after To the Hospital or within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edicai 29a. Certifier

9+

State Registrar

31. Date filed (Month, Dey, Year) DEC 1 9

29b. Signeture end title of cartifier

Tura

AURORA C. TAN, M.D.

9600 NORTH POINT ROAD, FORT HOWARD, MD 21052 32. Pegistrar's Signature Beneva

an.

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

29d. Dafe signed (Month, Dey, Year)

12-14-2000

AT CHEMISTER OF THE COMMISSION The state of the s

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: 1 PER PHY G792 2-8-01 WR. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) BLANCHE VIROSTKO GARNER 2. Date of Death Month **Physician** Blanche Virostko Garner December 12,2000 02:00AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 4110 Old Washington Road Waldorf Charles Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 282-18-0577 Director Ohio Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at 1X Yas 2 No Director Md. Charles Waldorf 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 4110 Old Washington Road 20602 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White à 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked othe any injury or other traumatic event base. 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Stephen Virostko Mary Dyrovy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Rita M. Angel daughter 262 Keith Court, Millersville, Md. 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Trinity Mem. Gardens 12-15-00 Waldorf, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Beall Funeral Home 20715 6512 N.W. Crain Hwy., Bowie, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Daath **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pancreatic Cancer with metastasis to liver Examiner Due to (or as a consequenca of): Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2⊠ No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 t ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 80 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2XXX 10 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred Certification: 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) after Direct 4 Homicide 24 hours Funeral 29a. Certifier *Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 **Two dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the To the 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number D28352 December 12, 2000

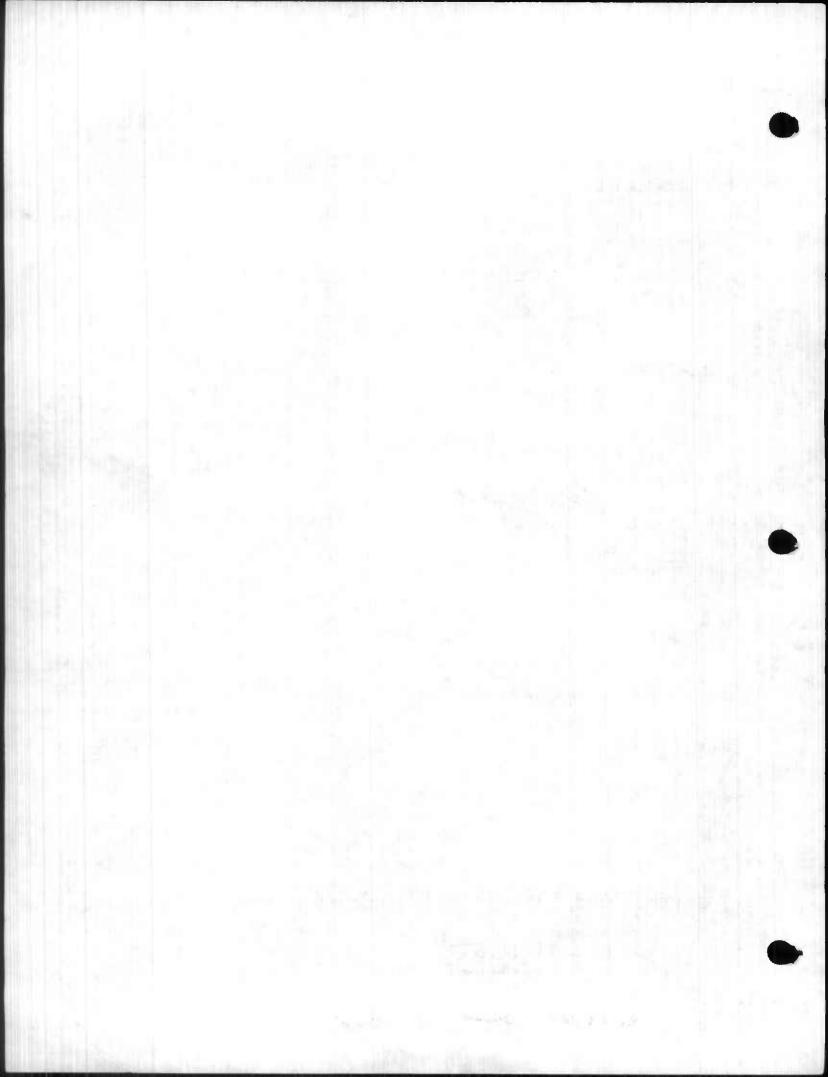
Registrar

31. Date filed (Month, Day, Year) DEC 13 2000

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

Krishan MAthur, MD., P.O. Box 1703, La Plata, MD 20646



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 9 per fh G791 1/8/01 yf Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day Year **Physician** Terence Felix Gastelle /Medical December 9.2000 9:42 am 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. July 31, 1923 5. Social Sacurity Number 6. Sex 1 → M 2 □ F 7. Aga (In vrs. last birthday) Birthpleca (Stata or Foraign Country) **Funeral** Months 77 Illinois 218-16-0006 Director Usual Rasidence of Deceden 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Nama 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo Takoma Park Maryland Montgomery the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20912 8109 Sligo Creek Parkway Funeral death 12. Wes Dacedant Ever in U,S. Armad Forcas? 1 (∑Yas 2 □ No If Yas, Giva Yaar or Datas: WWII Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indien, Black, White, etc. 72 hours after 1 Nevar Marriad 2 Merried 1 ☐ Yes 2 No Specify: Specify: White è. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Hygiena. Internal Revenue Serv. Public Relations Officer 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Mental marked Charlotte Martin Juan K. Gastelle 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 8109 Sligo Creek Pkwy. Takoma Park, MD 20912 and e m 19a. Informant's Name/Raletionship (Type, Print) Mary K. Gastelle/ wife Health Hem 27 other Baltimore, permit. Pages 1 Department of Hi Important: If hen any injury or oth once. 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Dec.15 Maryland Veterans Cemetery Crownsville, MD 2000 22. Nama and Addrass of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD 20910
23a. Part1. Enfar the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only on Approximeta Intarval Between Onsat and Death **Physician** immediata Causa (Finel disaasa or condition resulting In deeth) /Medical 5 hours . Acute hypovolemia Examiner Dua to (or es a consequance of): Physician/Medical Examiner 8 hours Acute gastrointestinal bleeding ed by the attending physician and detached for use as the burial-transit requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disease or Injury that initieted evants rasulting in deeth) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 N Yea 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease by of Vital Records. 24b. Were eutopsy findings available prior to complation of causa of daath? 24a. Was an eutopsy performed? Completed peen Atherosclerotic Cardiovascular Desease page 2 cartificate has 1 Tyas 2 No 1 □ Yes 2 □ No Pneumonia Physician: 25. Was casa refarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospitel: 1 ☒ Inpalient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yas 2 No this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mennar of Death Certification: 28c. injury at Work? After t Attending 1 Netural 5 Panding invastigation ipital or Attendin ours after death. erel Director: Aft filled in by the fur 1 Yas 2 No 2 Accidant 3 ☐ Suicida 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 1th Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Cartifier 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) December 9, 2000 10 + D46101 pleted cause of deeth (Item 23a) (Type, Print) 30. Nama and parass of person who/coff Gail* 8700 Georgia AVe. #400, Silver Spring, MD M.D., 20910 J. Povar 31. Data filed (Month, Day, Year) 32. Degistrer's Signeture State 15 DEC

DHMH 16 Rev 6/95

Registrar

100



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM#26 per phys G792 022001 SS 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** December 15, 2000 Liahue C. Gentry, Sr. 6:AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2624 Old Elk Neck Rd. Elkton Cecil If Under 24 Hrs 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Days Min. Months Hours 91-24-762 73 Taylors Valley Director 12-11-1927 Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow must be notified at Chester Oxford XXYes 2 No Director PA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Нета 23а 6 Grant Street 19363 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give² Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Bleck, White, etc. traumatic event, the Medical Examiner 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 ò 1 Yes 2√ No Specify: Specify.White þ 3. Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natueny injury or other traumatic event, trained once. 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Security Guard Scotts Corp. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be John A. Gentry Mary trent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 2624 Old Elk Neck Rd. Elkton, Md. 21921
ace of Disposition (Name of Dete 20c. Location - City or Town, Stete Sandra C. Dunn Daughter 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 1 Buriel 2 Cremetion 3 Removal from State Oxford Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12-19-00 Oxford, Pa. 19363 21. Signature of Funeral Service 22. Name and Address of Facility 86 Pine St. Edward L. Colling Jr Collins Funeral HomeOxford, Pa 19363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical fmmediate Cause (Final disease or condition resulting in death) ux Canco Examiner Due to (or as a consequence of): Examine physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 158 23b. Did tobacco usa contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to 1 Yea 2 No 3 Probably 4 Onknown þ Records, been signated 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ 110 Division of Vital 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Hooden 6 Mother (Specify) Hospitel: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After or Attending 1 Neturel 5 Panding investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) 29b. Signature and lifte of cyriftier 29c. License number 29d. Date signed (Month, Dey, Year) 15 nec D35653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.C.C.M.C. West Grove, Pa. 19390

32. Registrer's Signature Martha Hosford MD.

DHMH 16 Rev 6/95

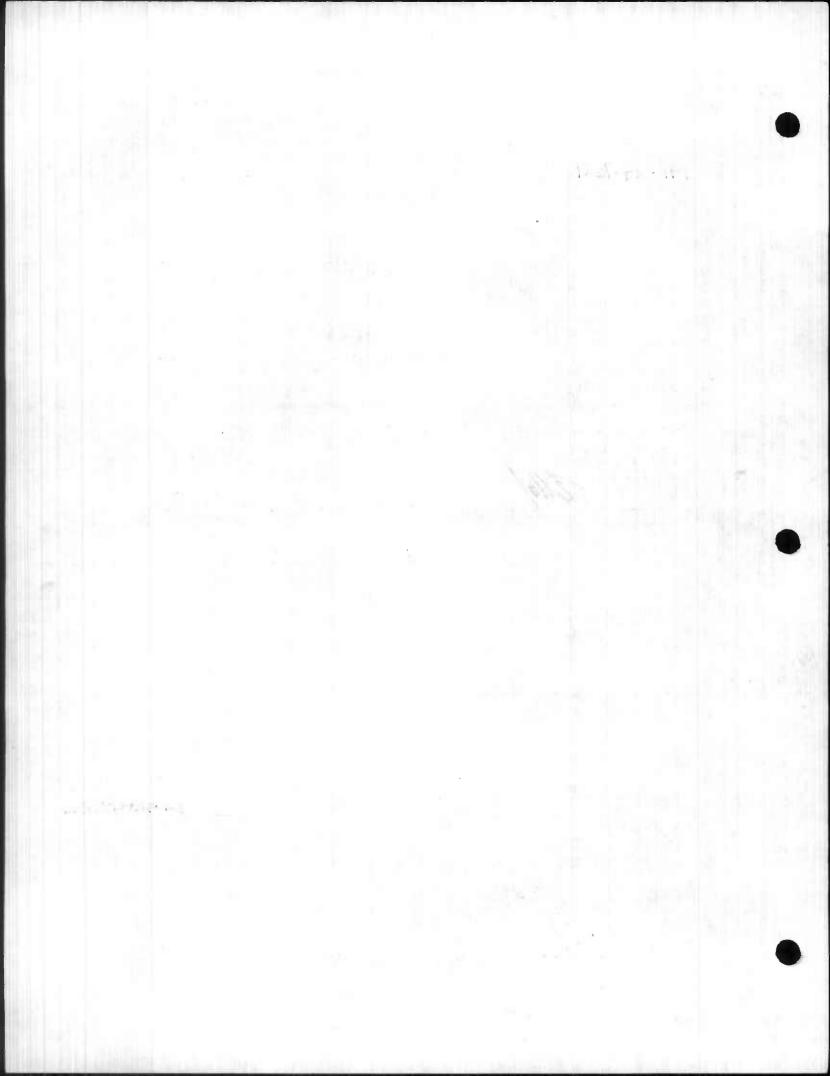
State

Registrar

31. Date filed (Month, Day, Year)

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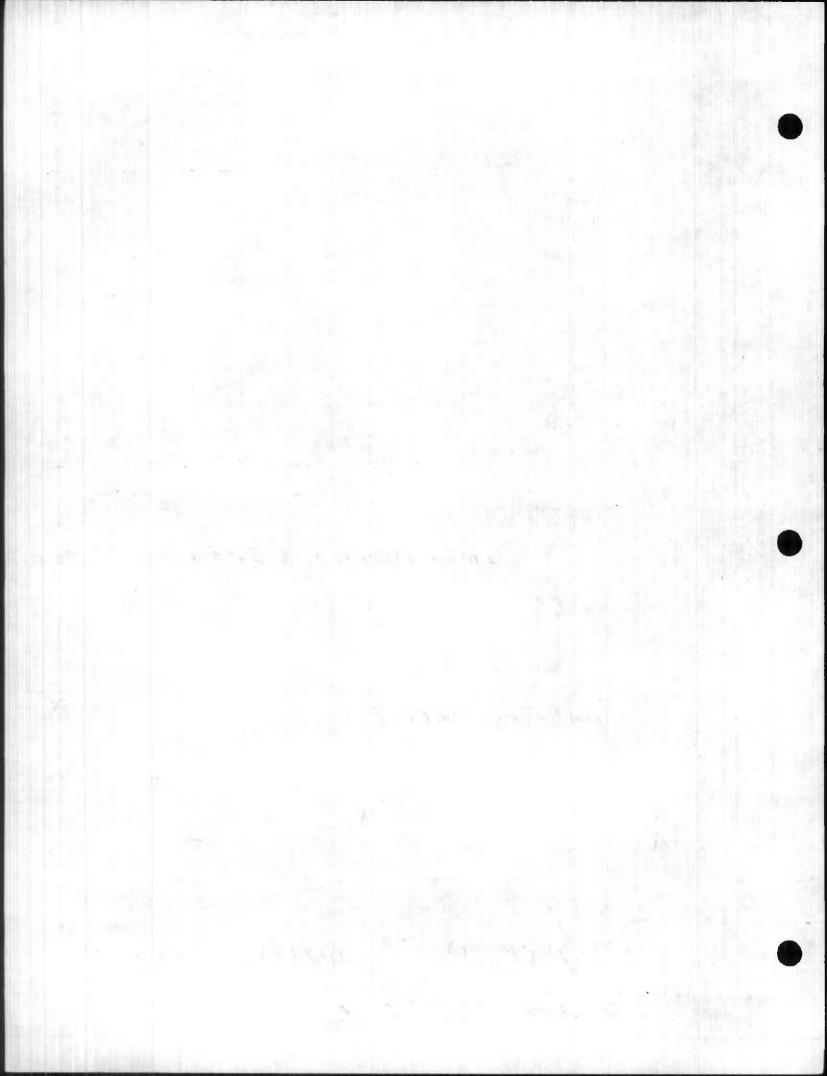


	Certificate of	Death	Reg.	. No.		
	Decedent's Name (First, Middle, Last)		2. Dete of Death Month	Day Yes		me of Deeth
Physician /Medical	Peter Joseph Hrip		ECEMBER	18, 2000	12:	26 A.M.
Examiner	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Loc	cation of Death	4c. County of De	eath	
		Leonardtow		St. Ma	- ale	
Funeral Director	5. Social Security Number 211-34-9433 6. Sex 7. Age (In yrs. last birthday) 1 f Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, You September	9. B 18, 1945	Birthplece (S Country) Pennsy	itete or Foreign Ivania
pu a	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location				10d insi	ide City Limits
Amyli man	Maryland St. Mary's California					Yes 2 No
or 28e-f sh be notified. Director	10e. Street and Number 10f. Zip Code		100	. Citizen of Whet (Country?	
2 44 10	45366 Abell Drive 20619	9		U.S.A.		
or items 23 aminer must y Funeral	11. Marital Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Narried 1 Yes, specify Cube 1 Yes, Specify Cube 1 Yes, Specify Cube 1 Yes, Specify Cube	Hispanic Origin? (Speen, Mexican, Puerto F		14. Rece - Ar Bleck, Wi		an,
vatural.	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		140			
ied within 72 ho hygiene. her then "naturn nt, the Medical.] Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired.)	pation during most of working d	161	b. Kind of Busines	ss/Industry	
with the Man	Elementery/Secondery (0-12) College (1-4or 5+) 12th Aircraft Mair			S. Contr	actor	
O A PAGE	17. Father's Name (First, Middle, Last)	18. Mother's Neme			actor	
Aental H Aental H Aced off Ilic even To Be			arie Ki			
Hound Man	19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street				e. Zip Code)	
and 2 and 2	Pamela Hrip (Spouse) 45366 Abell I					
Tion Tion	20a Method of Disposition 20b. Place of Disposition (Neme of			c. Location - City		
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tificate be executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): C				1	
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To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After toompletely filled in by the funeral Medical Certification:	end menner steted.					
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	1) And Austra	14285		12-18	-00	
	30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print)					
	William Boyd, II, MD Leonardtown,	Maryland	20650			
State	31. Date filed (Morrh Day, Year) 32. Registrar's Signeture	4				
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DHMH 16 Rev 6/95

HARRID, PETER JOSEPH

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Year Bernard 29 2000 John 5:35 PM 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Baltimore Maryland 6. Sex Medical System 7. Age (In yrs. last birthday) | H Under 1 Yeer University of Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foreign Country) Months Days 10 M 20 F Yrs 213-38-1881 63 February 10, 1937 Maryland Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2X No St. Mary's Mechanicsville Maryland 10f. Zip Coda 10g. Citizen of What Country? 10e Street and Number 38858 Wanda Lane 20659 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Maxican, Puerto Rican, atc.) Race - American Indian, Black, Whita, atc. 11 Maritel Status 1 X Yes 2 □ No If Yes, Giva 1 Nevar Marriad 2 Married 1 ☐ Yas 2 ☒ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Fleet Fuel Manager Oil Company 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Susan Helen Burroughs John Francis Hall 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 38858 Wanda Lane, Mechanicsville, Maryland 20659 Mildred A. Hall (Spouse) 20b. Placa of Disposition (Nama of cematary, crametory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ABurial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 12/4/00 Bushwood, Maryland Sacred Heart Cemetery 21. Signature of Funeral Service License 22. Nama and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. michael Never 23a. Part1. Enter the disease, or complications that caused the drum. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. P.O. Box 270, Leonardtown, Maryland 20650 Approximata Interval Batween Onset and Death Immediata Causa (Final Failure disaese or condition resulting in deeth) Cardio palmonury Dua to (or as a consequenca of): Fulminant Sepsis Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequenca of): Immuno suppression Dua to (or as e consequence of): Liver Transplant 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown End Stage Liver Disease 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Check only one) Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Tima of 5 Panding invastigation 1 Yas 2 No 6 Could not be

attending physician end for use as the burial-transit certificate be executed Box 68760 signed by the aid be detached for P.0. Division of Vital Records, been si The law page 2 s certificate has Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di After this

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29a. Cartifier (Check onl	Certifying Physician: To the best of my knowle Certifying Physician: To the best of my knowle Certifying Physician: To the best of		
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Hunghica O. Attient M. J.

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) atteine 11-19

Maryland Medical System 21201 0 Aticmom.o. Liniversity Humphrey 31. Data filed (Month, Day, Year)

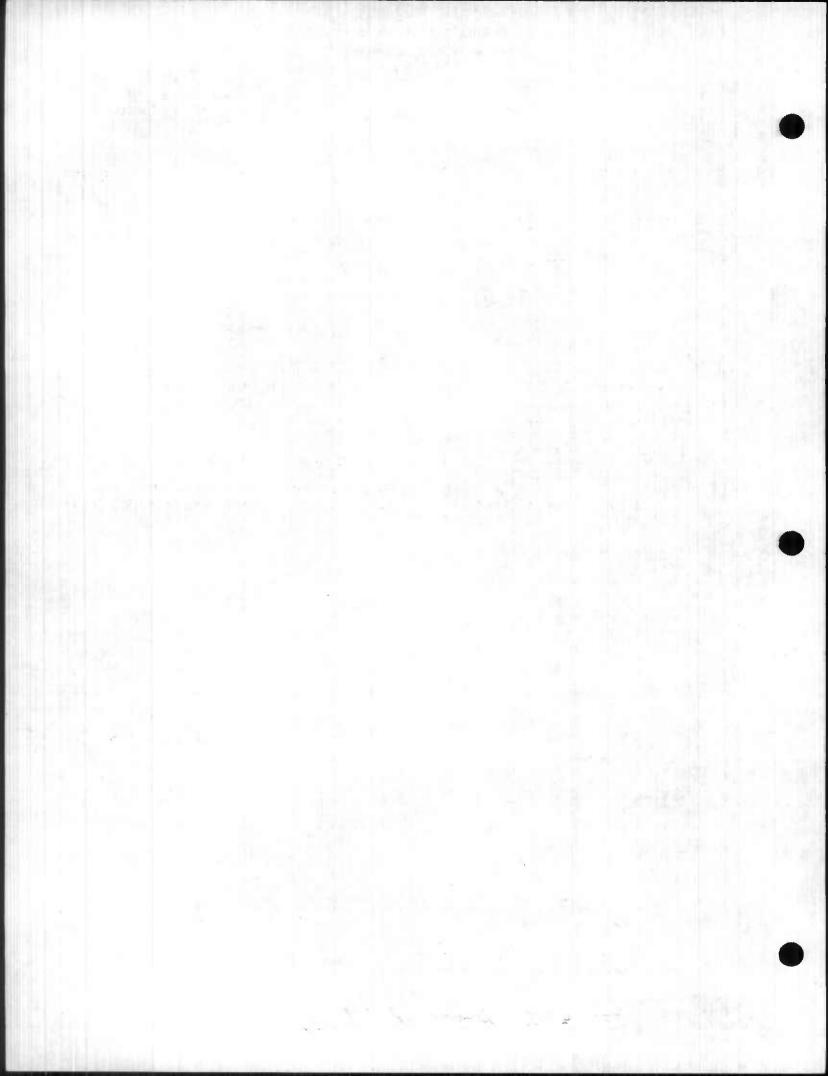
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32. Registrer's Signetura



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State of Maryland / Department of Health and Mental Hygiene UU

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** MELBA. CATHERINE HASTINGS 9:32 Pm December 12, 2000 cation of Deeth 4c. County of Deeth 2000 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth Examiner Princess Anne Manokin Manor If Under 1 Year 7. Age (In yrs. last birthdey) 5. Sociel Security Number 8. Dete of Birth (Month, Dev. Yeer) Birthpiece (State or Foreign Country) **Funeral** Months Deys Hours Min. 1 M 2 X F 90 213-18-4626 Vrs Director July 25, 1910 Maryland Usuel Residence of Decedent the Maryland r 28a-f show 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes **2**☐ No Director Maryland Somerset Deal Island 10e. Street end Number 10f, Zip Code 10g. Citizen of What Country? with 7 is marked other than "netural", or items 23a or traumatic event, the Medical Examiner must be a 24400 Hideaway Lane 21821 USA Funeral filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Status 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: by Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Hygiana. Receptionist Hospital Baltimore, Maryland 17. Fether's Name (First, Middle, Lest) . Pages 1 and 2 should be fill ment of Haalth and Mantal Hant: If Item 27 Is marked oth jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Wesley Beauchamp Rebecca Hadder 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Marilyn Reese/Granddaughter 949 County Rd., 847, Wadley, AL 36276 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or once. 12/15/00 Wicomico Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funerel Service Ligan 22. Name and Address of Facility
Holloway Funeral Home Professional Association CESP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner buriai-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Lest and Due to (or es e consequence of): Hastings 121 Records. P.O. Box 68760, Physician/Medical the Due to (or es e consequence of): USB 85 ate has been signed by the a page 2 should be detached f Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 KNo 1 ☐ Yes 2 No certificate neuma Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident death Director: 3 ☐ Suicide 6 Could not be determined in by t 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 D Homicide ò To the Hospital
within 24 hours a
To the Funerel C Hospital Medical 29a. Certifier 🗷 CertifyIng Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. ■ Medical Examiner: On the basis of examination end/or Investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. umpietaly 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 12-13-2000 14 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 200 GREGORIO M. BELLOSO, MD: 5302 CHINABERRY DR., SALISBURY, MD 2180/ 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

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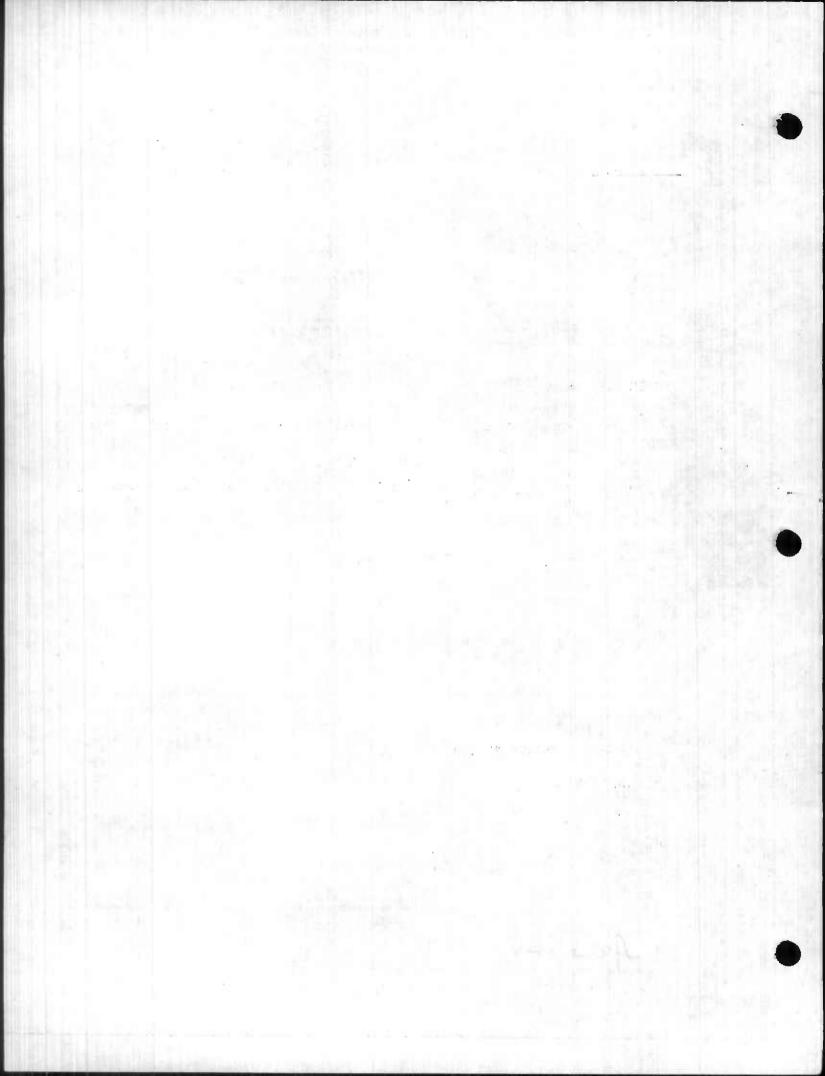
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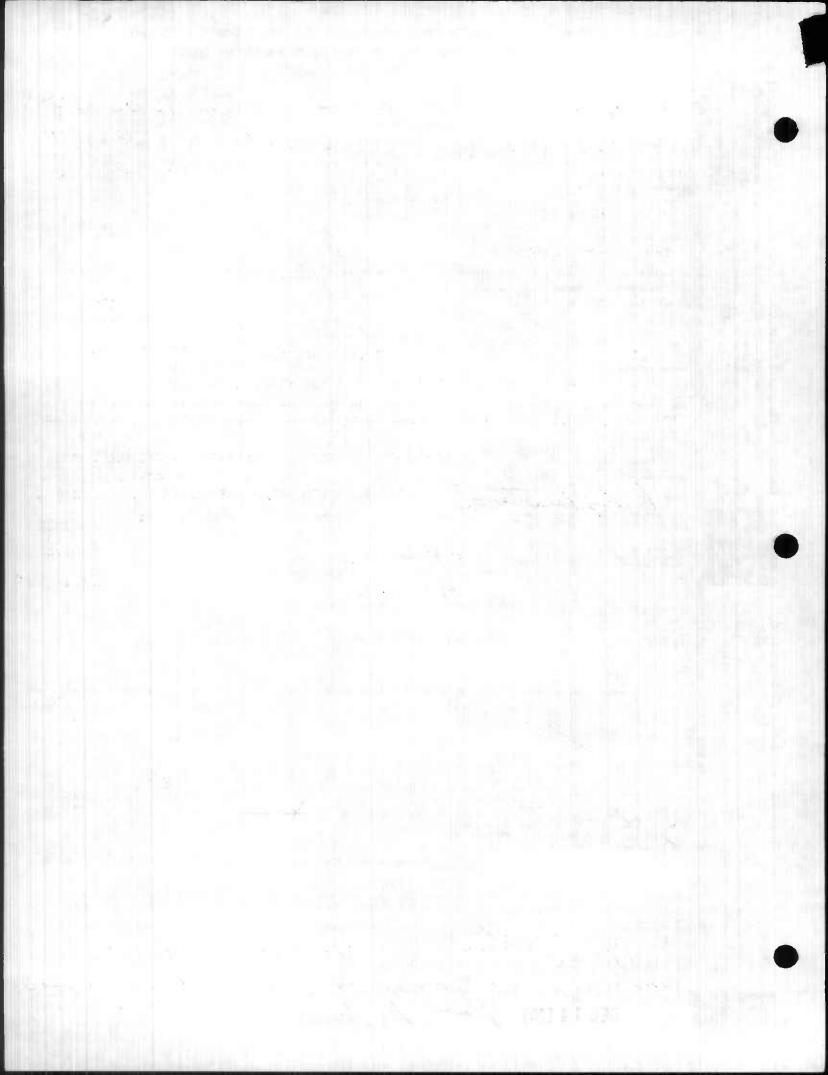
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				Certifica	te of L	Death		Reg. No.		
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Medical : caminer	4a Facility Name (If not insi PENINSULA	titution, give street and num REGIONAL ME		NTER	4	b. City, Town, SALIS	or Location of Deat	4c. County WICOM	of Deeth	
eral ctor	5. Social Security Number 221-22-7557	6. Sex 1 X M 2 ☐ F	7. Aga (In yrs. last	Yrs. If Und Month	ler 1 Yaar s Days	If Under 24 H Hours M	Irs. 8. Data of Bir (Month, Da 1/28/	th ly, Yaar) 1937	9. Birthpla Count DELA	aca (Steta or Forei ry) WARE
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o Be	EPHRAIM HITC	HENS				ALDA A	TKINS			
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To Be	examiner?	Hospital:	patiant 2 ER	VOutpatient 3□	DOA Oth	ar.	d Homa 5 ☐ Ras		ar (Spacify	1)
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Y	29b. Signatura and titla of c	pertifiar A	2	4	29c. Licens	9 7 y	9	29d. Date signe	U / Month, E	Day, Year)
4	30. Nama and addrass of prince in the Robins	erson who complated cause	of death (Itam 23	(Type, Print)	1/2	5.0	ahere-	MO.		
State	31. Date filed (Month, Day,	Year 8 2000 32. Re	gistrar's Signatur	a La	1	1,	- Junia	···		MIGN

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 8,19(per FD) 12/27 State of Maryland / Department of Health and Mental Hygiene () () Perf. H.) TCHD. 12/22/00, Sbb Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Dev Month Vee **Physician** JOSEPH FRANCIS HAGAN DECEMBER 16 2000 1725 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 24 Hrs If Under 1 Year 8. Dete of Birth (Month, Day, Year) 7. Age (In vrs. last birthdev) Birthplece (State or Foreign Country) **Funeral** Hours Min. 10XM 20 F Months Deys 78 MAR 27, 1922 Director MD 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits XXYes 2 No Director MD TALBOT ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? finer must be n 916 RIVERVIEW TERRACE 21663 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritel Status Bleck, White, etc. 'netural', or han deal Examiner 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: WHITE by 3 Widowed 4 Divorced the Medical Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry flied within 7 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) AGENT/ BROKER INSURANCE permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important. If Nam 27 is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be JOSEPH D.P. HAGEN HAGAN MARY HOPE HOPE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) HAGAN/ JOSEPHINE D. WIFE 916 RIVERVIEW TERRACE, ST. MICHAELS, MD 21663 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) ST JOSEPHS CEMETERY 12-20-00 CORDOVA, MD 22. Neme end Address of Fecility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA my'M Funeral Service a Lirensee 200 S. HARRISON ST EASTON, MD 21601 Approximete Interval Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) BRONCHOGENIC CARCINOMA Examiner Due to (or es e consequence of): Examiner attending physicien end for use as the burial-transit the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest Due to (or as e consequence of) O. Box 68760. Physician/Medical Due to (or es e consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 17 Yee 2 No 3 Probably 4 Unknown LOBAR PNEUMONIA RIGHT Division of Vital Records. b 24b. Were eutopsy findings eveileble prior to 24e. Wes en autopsy performed? Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE completion of ceuse of deeth? is certificate has b 2 No 1 Yes 1 ☐ Yes 2 ☐ No ATRIAL FIBRILLATION Physician: 25. Wes cese referred to medical Be 26. Plece of Deeth (Check only one) Hospitel Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending 5 Pending Investigation 1 X Neturel death. 1 Yes 2 No Director: / 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide after 6 To the Hospital o within 24 hours aff To the Funeral Di completely filled in edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier MID D0052861 12/17/00 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) ASHA VAL M.D. 9801 GEORGIA AVE, SILVER SPRING, MD 20902 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Buch DEC 1 8 2000 Registrar





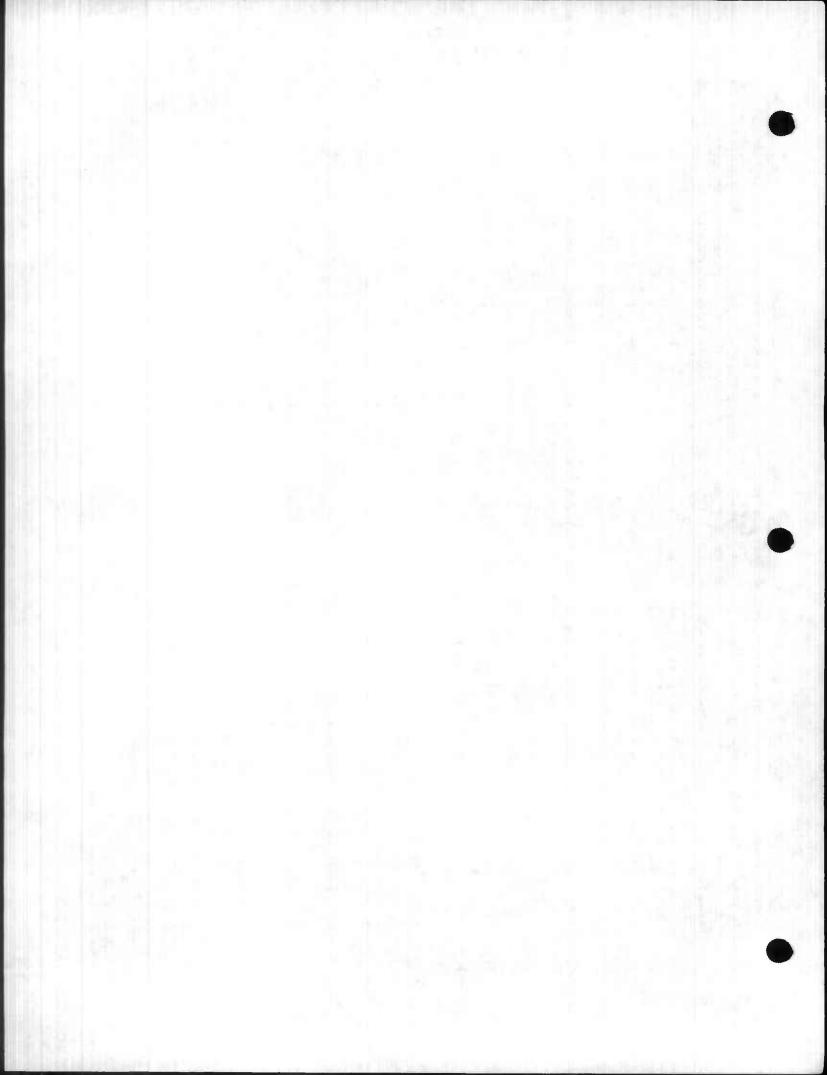
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State of Maryland / Department of Health and Mental Hygiene 0 4 2 4 3 7

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Juanita Lenora Dauphin Harper December 13, 2000 8:00 P.M. /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Spring Brook Adventist Health Care Center Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (State or Foreign (Month, Day, Yeal) 906 9. Birthplaca (Month, Day, 5. Sociel Security Number **Funeral** 1 M 2 Hours 425-70-8118 94 Director September 6, Louisiana Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 XYes 2 No Directo Maryland Montgomery Silver Spring 28e-f 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be a 12325 New Hampshire Avenue 20904 United States Funeral Spring Brook Adventist Health Care Center 12. Wes Decedent Ever in U,S. Armed Forces?

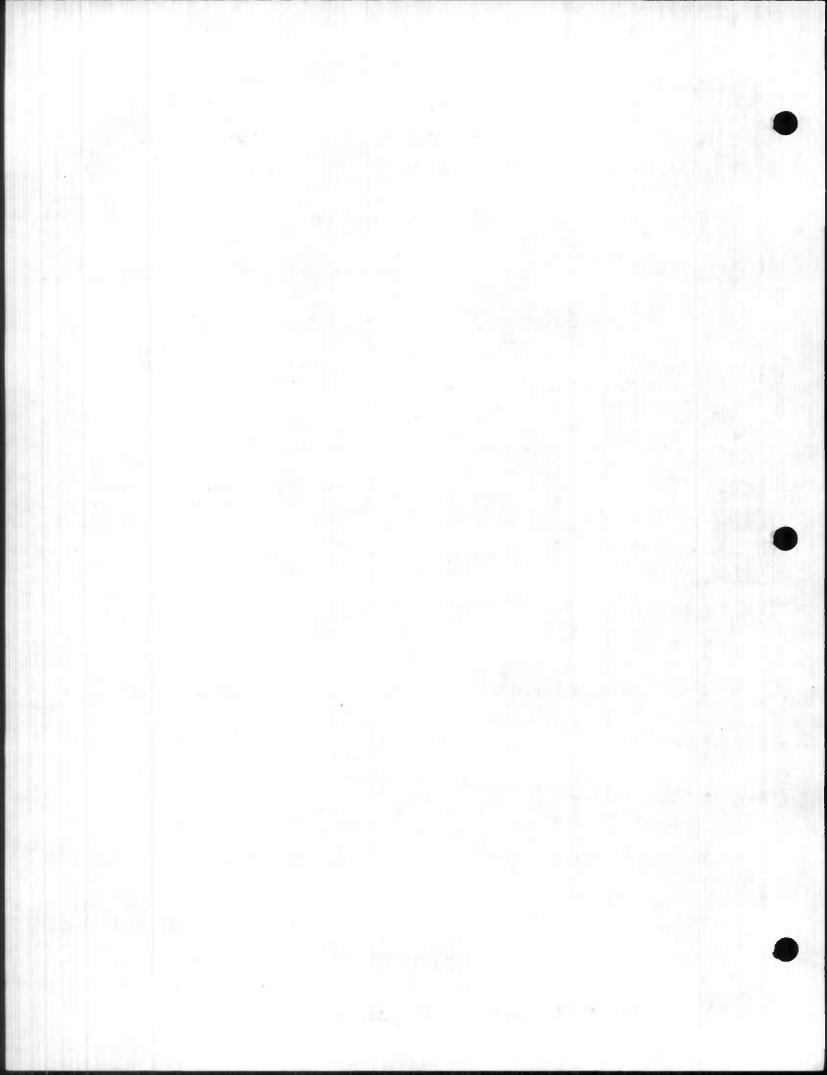
1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Merried 2 Merried à 21215-0020 1 Yes 2 No Specify: **Black** Specify: þ 3 XWidowed 4 ☐ Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12)
11th grade College (1-4or 5+) Housekeeper Domestic Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) parmit. Pages 1 and 2 about be the Department of Health and Mental Himportant. If them 27 is marked oth any injury or other traumatic event 88 William Joseph Dauphin Willie Mae Swinney 19e. Informent's Neme/Reletionship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Ida Lenora Harper Suggs Brown 13 Timber Rock Road; Gaithersburg, Maryland 20878 20b. Place of Disposition (Nama of cemetery, cremetory or other place) Dec. 21,2000 20e. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from Stete 4 Donetion 5 Other (Specify) Chesapeake Crematory Beltsville, Maryland 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee R. N. Horton Company Morticians, Inc. anomak cuam 600 Kennedy STreet, N.W.; Washington, D.C. 20011 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset and Death **Physician** /Medical Immediate Cause (Finel Years diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Diseese or injury that initiated events resulting in death) Lest and Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 88 980 signed by the e Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital Attending Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: AX Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of injury (Month, Day Year) 27. Mennar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner steted. (Check only one) 29c. License number 29b. Signature and title of cartifier 29d. Data signed (Month, Day, Year) D43237 December 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Armstrong, M.D.; 14201 Laurel Park Drive, Suite 102; Laurel, Maryland 20707 31. Dete filed (Month, Dey, Year)
DEC 1 8 2000 3:2 Registrer's Signeture

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month 2:25 Am 19 2000 Jeffrey David Harash 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Prince George's Hospital Center Cheverly
If Under 24 Hrs. Prince George's 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 2M 2□ F Months Days Hours Min 216 80 7170 37 July 24,1963 Great Falls, MT Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2611 Kimble Lane 20715 United States 12. Was Decedent Ever in U,S. Armad Forcas? 1 ☐ Yes 2 ☑ No It Yes, Give Yaar or Dates: 14. Race - American Indian, Black, White, etc. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 1 Navar Married 2 Married 1 Yes 2√2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elementery/Secondary (0-12) College (1-4or 5+) 12 Construction Worker Construction 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) Gary John Harash Emily Jane Wolfe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gary John Harash 2611 Kimble Lane Bowie Maryland 20715 Father 20c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) December 22, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Timothy's Church Cemetery Smithton, PA 22. Nama and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Daath Immediata Ceuse (Final disease or condition resulting in death) EMPAY EMEA Due to (or es e consequence of) PNEUMONIA. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca ot): Due to (or as a consequence of):

Physician /Medical Examiner

physician and the buriel-transit

ettending for use es

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page 2 s certificate has

director,

After this funeral

To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: A completely filled in by the fi

deeth.

that the death certificate be executed

The law requires

or Attending Physician:

Box 68760

P.0.

Division of Vital Records,

Examiner

Physician/Medicai

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Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

the Meryland

with

filed within 72 hours after death

Battimore, Maryland 21215-0020

Jean Peges 1 and 2 should be filed within 72 hours after describing to Health and Mentel hygiene.

Important: If Item 27 is marked other than "natural", or item in high or other traumatic event, in Medical Evan repose.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to

completion of cause of death?

1 Yes 2 KNO 1 Yes 2 No

25. Was case reterred to medical examiner? 1 Yes 2 No

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 28c. tnjury et Work?

26. Plece of Deeth (Check only one)

28d. Describe how Injury occurred 1 Yes 2 No

28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Menner of Death

2 Accident

3 Suicide

4 Homloide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of emifier

29c. License number

29d. Data signed (Month, Day, Year)

5 Pending investigation

6 Could not be

-6100.

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

BERZHANE M 15102 301Chever/u

State Registrar 31. Data tilad (Month, Day, Year) DEC 2 0 ZUUU 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** December 6, 2000 1634 Joseph Howell /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5 Social Security Number If Under 1 Yeer 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1X M 2□ F Months 215-12-2023 78 Yrs. Mar. 19, Maryland Director 1922 Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Wedical Examiner must be notified at 1 X Yes 2 □ No MD. Allegany Barton Director 10e. Street end Number 10f, Zip Code 10g. Citizen of Whet Country? 21521 18932 High St. United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1X Yas 2 No If Yes, Give 1942 Year or Detes: 1942 1⊠ Never Married 2 Merried Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Manager Banking 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be 2 should be fi end Mental P ie marked Charles Logsdon Howell Martha 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rurel Route Number, City or Town, Stete, Zip Code) of Health en Emily Hyde/ friend 19518 Hyde Road, Barton, Maryland 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 12/09/ important: If he any injure Pages 1 p⊠Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete St. Gabriels Cemetery Barton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Funarel Sarvice Licensae 22. Name and Addrass of Facility Boal Funeral Home 111 Church St. Westernport, Maryland 21562 23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Acea /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) 9: olleweller Examiner Examiner valles neeteo sician end burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): mou fe signed by the attending physician Physician/Medical Dua to (or as a consequence of) as the NOOV 49 Rucel Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uee contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ð 24b. Were eutopsy findings availabla prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed certificata has 1 ☐ Yes 2 ☑ No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical Be 26. Piece of Death (Check only one) Hospitel: Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify) 2 1 Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this Certification: 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Maturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be 3 Suicida 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) or A after 4 Homicide To the Hospital of within 24 hours a To the Funeral D completely filled in 16 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner steted. edicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1000 8377

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) State

John Mehanna

Drive, Cumberland, Maryland 21502 902 Seton

December 8

2000

31. Date filed (Month, Dey, Year)

DEC 1 1 2000

accesse

32. Redistrer's Signeture

Registra **DHMH 16 Rev 6/95**

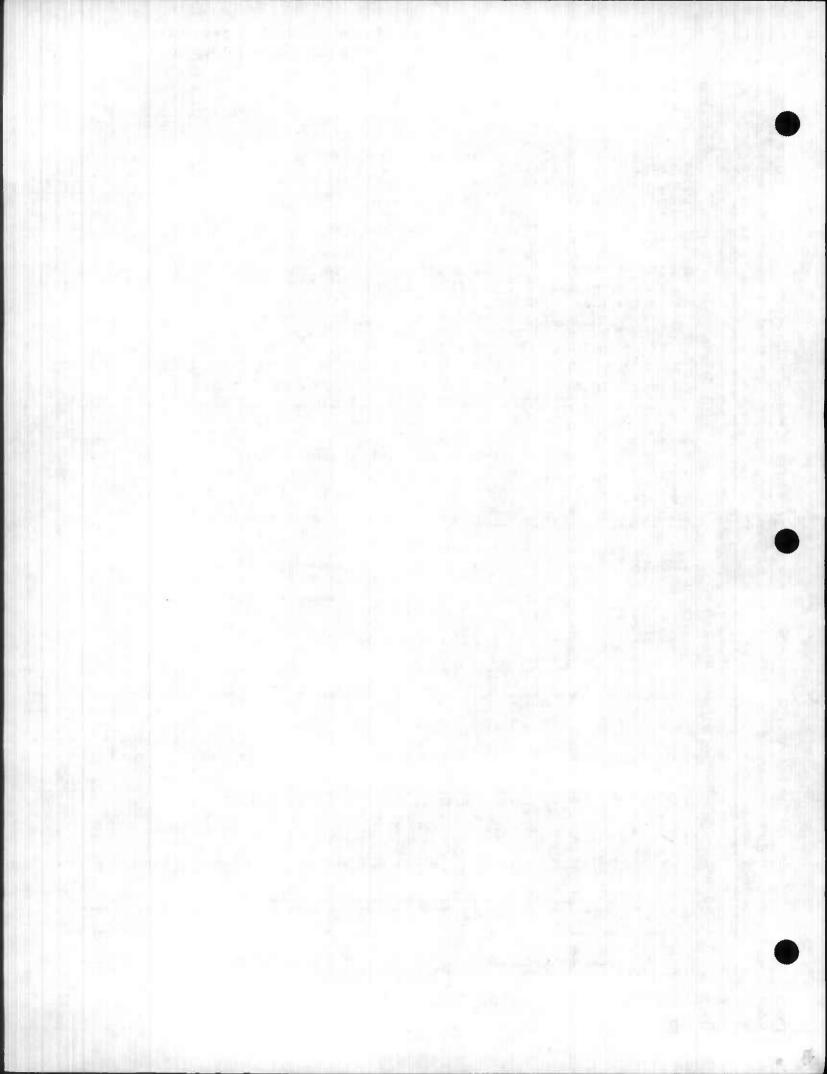
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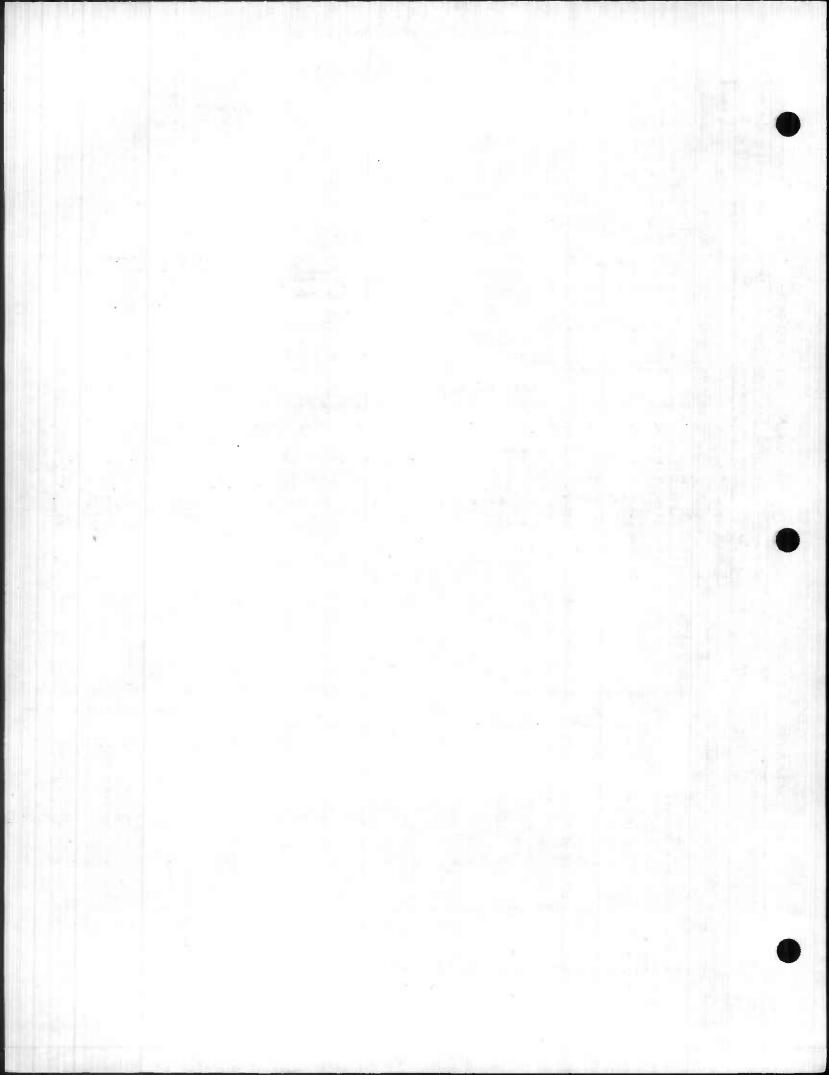
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Physician	1. Decedent'a Name (First, Middle, La Joyce Ann Ham					2. Date of Do	Day Year	3. Time of Death 2040
/Medical Examiner	4a Facility Name (If not institution, give				4b. City, Town, or I	.ocation of Deer	h 4c. County of Dee	eth
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Funeral Director	213-68-1461	Sex 7. Age (In yrs. 4	-	Months Days	r If Under 24 Hrs. Hours Mio.	8. Date of Bi (Month, D. ugust	28°,1954	rthplace (Stete or Foreign ountry) Pa •
72 hours after death with the Maryland natural; or items 23e or 28e4 show deal Examine must be notified at each by Funeral Director	Usuel Residence of Decedent 10a. Sfefe 10b. County		ty, Town or Loc					10d. Inside City Limits
e Man	De. New C	Castle M	iddlet	own				1 Yes 2 No
r teme 23e or 28e-1 e	10e. Streef and Number 209 West Mair	Street		10f. Zip Code	19709		10g. Citizen of What C USA	ountry?
natural, or items 23s or 28s-f show toles Examine met be notified at leted by Funeral Director	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	19	Vas Decedent of Yes, specify Cul	Hispanic Origin? (S ban, Maxicen, Puert Specify:	pecify Yea or No Rican, etc.)	Black, Whi	
"natural", adeal Ev	15. Decedent's E (Specify only highest gr	ducetion ade completed)	16a. Deced	ent's Usual Occu	ipation a during most of wor ed)	king	16b. Kind of Business	s/Industry
then the	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	emaker			At hom	ie
umetic event, to To Be Co	17. Fether's Name (First, Middle, Last	")			18. Mother's Nar Ethel		o, Maiden Sumame)	
27 la m r traum	19a. Informant's Name/Relationship (Bruce Hamm, Sr		19b. Mailin 209	g Address (Stree West M	Main St.	, Midd	per, City or Town, State, letown, D	Zip Code) De. 19709
ant: If Item 27 ury or other tr	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removel from State F1	cemetery, crem	sition (Name of natory or other pla Cemeter	ece)		20c. Location - City of Elkton,	Md.
Important: If any Injury or pace.	21. Signature of Funeral Service Uch	nsee	- (Name and Addr			E. Main Son, Md. 2	
	23a. Pert1. Enfer the disease, or com shock, or heart failure. List only	nplications that caused the deer	th. Do not ente	er the mode of dy	ring, such es cardiac	or respiretory	errest,	Approximete Interval Between Onset and Death
ending physician end mirrors truse as the bunal-trensit	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlittled events resulting in death) Last	b. Metristate So Due to (uence of):		& Meh	enque	gen
d by the attendatached for u	Pert II. Other significant conditions of	contributing to death but not res	sulting in the ur	nderlying ceuse g	iven in Part I.			le to the cause of death?
igned by be deta by Ph						16	2□ No 3□1	Probably 4 Unknown
2 should						24a. We	s an autopsy 24b cormed?	Were autopsy findings available prior to completion of ceuse of death?
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his certification of director	25. Was cese referred to medical examiner? 1 Yes 2 No	Hospital: 1 Thipatient 2	ER/Outpatien	1 3 DOA O	26. Place of Dea		one) idence 6 □Other (Sp	ecity)
도 등	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj			how injury occurred	
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined		ome, farm, stre	eet, factory, office	9		(Street and Number or I own, State)	Rural Route Number,
he Funeral pletely filled edical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	, and due to the rred at the time	e cause(s) and manner a , date end place, and du	as stated. ue to the cause(s)
To the	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed (Mor	oth, Day, Year)
	Lte Je	uu Mo			00190	43	12/14	100
?	30. Neme and address of person who		n 23a) (Type, I		MIDDLET	NUN. N	E 19709	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					
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ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificat	e of	Death		Reg. No.		7-746
	1. Decedent's Name (First, Middle, Las	t)					2. Date of D	eath	Mon	3. Tima of Death
Physician /Medical	John He	nry Irelan	d				Decem	ser 13 g	Year 2000	3:50 Pm
Examiner	4a Facility Nama (If not institution, give				4	lb. City, Town, o	r Location of Dea	th 4c. Count	y of Death	
	Carline Nursing	Home, Inc				Denton	1	Carol	ine	
Funeral	5. Social Security Number 6. Se		yrs. last birthday		r 1 Year	If Under 24 H		irth	9. Birthp	lace (State or Forei
Director	212-14-8875 Usual Residence of Decedent	X M 2□ F	8 5 Yrs.	Months	Days	Hours Mi		4, 1915	Mary	
Man Man	10a. Stata 10b. County	100	City, Town or L	ocation					10	Od. Inside City Limit
vith the Man or 28s-f sh be notified Director	Maryland Caroline		Denton							1□Yas 2□N
or 20	10e. Street and Number			101. Zip	Code			10g. Citizen of	What Coun	try?
th wi	26136 Hobbs Road			21	1629			United	State	S
ifter death v	11. Marital Status	12. Was Decedent Evar Armed Forces?	in U,S. 13.	Was Dece	dent of H	ispanic Origin?	Specify Yes or N	o- 14. Ra	ce - Amarica	an Indian,
within 72 hours after death with the Maryland shan "natural", or items 23s or 28s-f show he Madesi Examine must be notified at military must be notified at military must be notified at military must be notified at military must be notified at military must be notified at military must be not market by Funeral Director.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Giva Year or Dates:		1 ☐ Yes	12.00	n, Mexican, Pus Specify:	ino rican, etc.)		ick, Whita, a fy: .ucasi	
d within 72 hours at plane. It than "natural", or the manual or the manu	15. Decedent's Ed		16a: Dece	dent's Usu	al Occuo	ation		16b. Kind of B		
led within 72 ho yglene. Nor than "naturn it, the weder	(Specify only highest grad	de completed)	(Give	kind of wo	vk done	during most of w	orking	TOD. TUNG OF E	7431110331110	iodity
withir than than	Elemantary/Secondary (0-12)	College (1-4or 5+)	Poult	rv Se	rvi	e Man		Poul	trv	
	17. Father's Name (First, Middle, Last)		1001	JIY De	STATE		ame (First, Middle			
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should be and Mental a marked o numatic av			-		(0)					
d 2 should be tile d 2 should be tile th and Mental Hy 7 is marked othe traumatic avent	19a. Informent's Name/Relationship (7						Pural Route Num			Code)
	Pearl E. Ireland	Wife				oad, Den	ton, Ma	-		
95-	20a. Mathod of Disposition 1 □xBurial 2 □ Cremation 3 □		b. Place of Disp cemetery, cre	matory or c	ne or other plac	e)	Data	20c. Location	- City or To	wn, State
nit. Pag artmanl ortant: injury	4 □ Donation 5 □ Other (Specify		Denton (Cemete	ery		12/14/0	Denton	, Mar	yland
pemit. Pages 1 ar Department of Hea Important: if Itam; any Injury or other pance.	21. Signalette of Funeral Service Licens	PMark	N	loore	Fune		ne, P.A.			
	23a. Part1. Entar the disease, or comp shock, or heart failure. List only of	" LOONE							Maryl	Approximata
/Medical Examiner	Immediata Causa (Final diseasa or condition resulting in death)	a. Pulmono	to (or as a conse	quence of):	05	S			1	year
death certificate be executed that the same of the sam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с	o (or es a conse						1	
T 0 5	resulting in death) Last	d		,						
at the death certified by the attending etached for use a Physician/M									1	
the de ached	Part II. Other significant conditions co	ntributing to death but not	resulting in tha u	enderlying o	eusa giv	en in Part I.	23b. Dic	tobacco use co	ontribute to	the cause of deat
	Dirbetes	Mellitus					10	Yes 2 No	3 Prob	pably 4 ☐ Unkno
							24a. Wa per	s an autopsy lormed?	cor	ara eutopsy findings allable prior to mpletion of cause death?
The level at the has page 2							400	Yes 20 No		Yas 2010
cartificate rector, pa	25. Was case referred to medical								1	J Tas ZETNO
Physician: this cartition ral director, TO Be C	axaminer?	Hospital:			Oth	00-	aath (Check only			
this aldi	1 ☐ Yas 2 ☐ √No 27. Manner of Death	1 L Inpatient	2 ER/Outpatie		JA	4023 Nursing	Home 5 Res			0
B and o	1- Netural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Yea	r) 28b. Time of Injury	M	28c. Injun Work	yes 2 □ No	28d. Describe	how injury occu	med	
To the Hospital or Attanding P within 24 hours after death. To the Funeral Diractor: After the completary filled in by the tuners. Medical Certification:	3 Suicide 6 Could not be 4 Homicide detarmined	28e. Place of Injury - / building, etc. (Sp	At homa, farm, st ecify)	reet, factor	y, office		28f. Location City or To	(Street and Num own, State)	ber or Rura	l Route Number,
he Hospit in 24 hour he Funer pletaly fill edical	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of my ner: On the besis of axan and manner steted.	knowledge, deat nination and/or in	h occurred vestigation	at the tim , in my o	ne, date and place pinion, death occ	ce, and due to the curred at tha time	cause(s) and m , date and place,	ennar as st and due to	ated. tha cause(s)
Neithir Somp	29b. Signatura and titla of certifier			290	. License	number		29d. Date signe	ed (Month, I	Day, Year)
F > F 0	1 James &	wes M	0	I	3	1376	5	12-11.	00	
	30. Name and address of person who co	ompleted cause of death (Item 23a) (Type,	Print)						21, 41 1
	James Sides, M.D.	PO Box 496	, Dento	n, Mai	rylai	nd 21629)			
State	31. Data filed (Month, Day, Year)	32 Registrer's S	ignature 6	don	Mar	,				1111



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

							C	ertifica	ate of l	Death			Reg. No.		
			1. Decedent's Nema (First, Middla	, Last)	11		FIELD NO.					2. Data of De		Veer	3. Tima of Death
	Physicia	_	IIn agrain to M	- F	T	hace						Month Decem	ber 26,	Yeer 2000	8:40 AM
	/Medic		4a Facility Nama (If not institution,							th City To	own, or Lo	cation of Deat			
	Examine	er				111001							1111		
1			43750 Raspber							Holly			St.	-	
	Funeral		5. Social Security Number	6. Sex		7. Aga (In yrs		Month	dar 1 Year na Days	If Undar Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birth	place (Stata or Foreign intry)
	Director		218-18-4947	1	M 20XF	77	Yrs.						12,1923		ryland
	Q		Usual Residence of Decedent												
	ylen Mor		10a. Sfata 10b. County			10c. C	ity, Town or	Location							10d. Inside City Limits
	We T	Ö I	Maryland St. M	lars	10	Н	ollyw	fron						3.3	1 ☐ Yas 2√ No
	15 28 a	8	10e. Street and Number	ar. y		-	OII) W		Zip Code				10g. Citizen of W	Vhat Cou	intry?
	72 hours efter deeth with the Maryland natural", or Rema 23a or 28a-f show dreat Examinan mast be notified a	Funeral Director											** 0		
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0	or h	E	1 Never Married 2 Marri	ed	1 Tas	2 XNo		1□ Yes	2 X No	Specify			Specify	Whi	te
21215-0020	Surgar Para	þ	3 XWidowed 4 ☐ Divorced		Yaar or I	Dates:			21					*****	CG
0-0	netur	Be Completed	15. Decedent				16a. De	cedent's U	suel Occup work done	etion	et of work	ina	16b. Kind of Bu	siness/In	ndustry
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27	iene.	E	Clementery/Secondery (0-12)		2 ye		R	enist	ered	Mirse	2		Heal	th C	are
D	be filed that Hygid dother event, t	0	17. Father's Name (First, Middla, L	ast)	- Yu	ara		ug111	CICC			(First, Middle	, Maiden Sumam		
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7	should be ind Menta in marked umatic ev	2	Albert Richard				1		10:	Mai			arroll	Carte 7	in Cordal
-	O1 00 00 40		19a. Informant's Name/Relationsh										per, City or Town,		
	こるのよ		James Carroll Wa	lla	ice (N					Tra	il, M	ledford	, New Je:		
=	S 70 2		20a. Method of Disposition		4		Place of Discemetery, of	sposition (/ crematory o	Name of or othar plac	:е)	1	Date	20c. Location -	City or T	own, State
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	1000		michael 9	120	un >	Varde	ra A	P.O.	Box 2	70, I	eona	rdtown	, Marylan	nd 2	0650
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	Physician														Onset and Daath
	/Medical	8	Immediate Causa (Final		S	epsis									Immediate
00.00	Examiner		diseasa or condition resulting in death)	8		-			-A.						
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	eath certificate be axecuted attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying		Α.	theros	or es a con			n In	anff:	oienov			Five Years
90	cian cian	<u> </u>	Ceuse (Diseese or Injury		21	forter ope	reion	TC 45	SCULO	LL LLI	5 UL 1, 1	CTCHCA			
68760,	hysi the t	edical	that initiated events resulting in death) Last			Due to (or as a cons	sequence o	of):					i	
9	nd po	<u>ه</u>													
Вох	endii use	2		- 0				11/11/11						1	
	death e atten	Physician	Pert II. Other significant condition	ne con	tributing to	death but not re	sulting in the	e underlyin	no causa div	en in Part	1.	23b. Dic	tobacco use coi	ntribute	to the cause of death?
Ö	that the de ed by the detached	Š	Hypertension						3			1.	Yes 2 No	3□Pn	obably 4 Unknown
0	£ % 0		V 1										100 1010	00,11	, , , , , , , , , , , , , , , , , , , ,
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0	been sign	Completed											omed?	8	vailable prior to completion of ceuse
0	has by	G.				7.27							No		of death?
	The laste he page	E										10	Yes 2 No	1	□ Yes 2□ No
	delan: The		25. Was cese referred to medical							26 Place	e of Deal	h (Check only	onel		
5		o Be	examiner?	Н	lospital:	I Impation to T	7.50/0-4	tiont of	DOA Oth	or:		ne.		01/0-01	264
of	Phys this rai di	- 10	27. Manner of Death				28b. Time		DUA	4111	ursing Mo		how injury occur		417)
n	After fune	0	1 Neturel 5 Pending		(Mo	of Injury nth, Day Year)	Injur	y	28c. Injur Wor		1Nc				
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2	r At rect	=	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined	28e. Plac build	e of Injury - At I	home, farm,	street, fac	tory, office				(Street and Numb own, State)	er or Ru	ra! Route Number,
0	rs after al Dir	Certification:													
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	(Check only 2 Medical I	xamir	ner: On than	hairs of exemin finer stated.	etion and/o	rinvestiget	ion, in my o	pinion, de	etn occur	ed et the time	, date end place,	and due	to the cause(s)
	within 2 To the I	M	29b. Signature and little of cytiline	/	111				29c. Licens	e number			29d. Dafe signe		
	- 5 - 0			1	411	NSO			Maryl	land	DU2:	159	December	28,	2000
			7	*	1	7/0									
	12		30. Nama and addrass of person Eugene Guarant	WITO CO	mplated cau	ise of daeth (Ite	m 23a) (Ty	pe Print)	2777 25	31.2	Himm	r Road	Chantio	0. 1	m 20021
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	Stat	e	31. Data filed (Month Pay, Year)	7 00		Registrar's Sign	nafure	4	-						
	Registra	ır	DEC 27	7 20	UU	Deput	~	0.	Low	de					

Second But

Jan 19 2000 Present

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** dron 5-2000 3:05 Pm 12 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey. Yeer) July 12, 1939 Georges er 6. Sex 7. Age (In yrs. last birthdey) Prince George 5. Social Security Number Birthpleca (State or Foreign Country) 1□ M 2 F **Funeral** Deys Yrs. Director 213-40-5004 Germany Usual Residence of Decedent 10d. Insida City Limits 10a. Stete 10b. County 10c. City, Town or Location show rai', or items 23a or 28a-f show Examiner must be notified at 112 Yes 2 □ No Director Md. Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12305 Rustic Place 20715 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Reca - American Indien, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiona. Important: if item 27 is marked other than "natural", or iten eny Injury or other treumatic event, tre Mexical Experience and page. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 3€ No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Logistics specialist 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Heinz Skiebe Hildegard Malzahn 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Elmer K. Jaindl husband 12305 Rustic Place, Bowie, Md. 20715 20b. Pleca of Disposition (Neme of cematery, crematory or other plece) 20a. Method of Disposition 12-16-00 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removel from Stete Metropolitan Cremator 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA. 21. Signetura of Funerel Spr 22. Name end Address of Fecility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Pert1. Enter the diseasa, or complications thet caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician fmmediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of Examiner conce that the death cartificate be executed ician and burial-trens Sequentially list conditions, if any, laeding to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in deeth) Last Due to (og as a consequence of) Box 68760 Physician/Medical Dua to (or es e consaguance of): P.O. ate has been signed by the a pege 2 should be datached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. P Completed 24b. Were autopsy findings aveileble prior to 24a. Was en eutopsy performed? completion of causa of death? 1 ☐ Yas 2 ☐ No 1 Yas certificate Division of Vital or Attending Physician: director Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this Mannar of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. fnjury et Work? 28d. Describe how injury occurred After Neturel 5 Pending investigation Hospital or Attending 24 hours after death.
 Funeral Director: After 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide 28a. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 4 | Homicide filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and menner steted. 29e. Certifier Medical pletaly (Check only one) To the To the

State Registrar

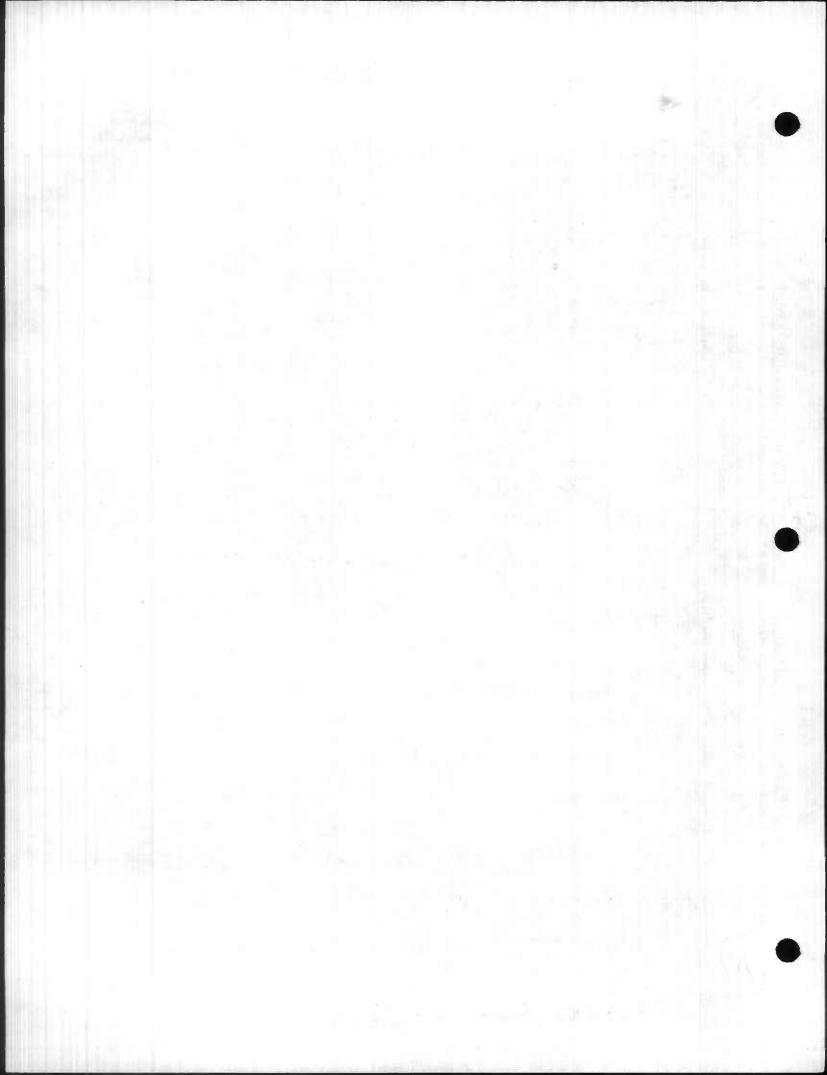
James Catavenis MD, 3001 Ho
Date filed (Month, Dey, Year) 32. Registrar's Signatura 3001 Hospital Drive, Cheverly, Md. 20785 31. Date filed (Month, Dey, Year) DEC 18 2000

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

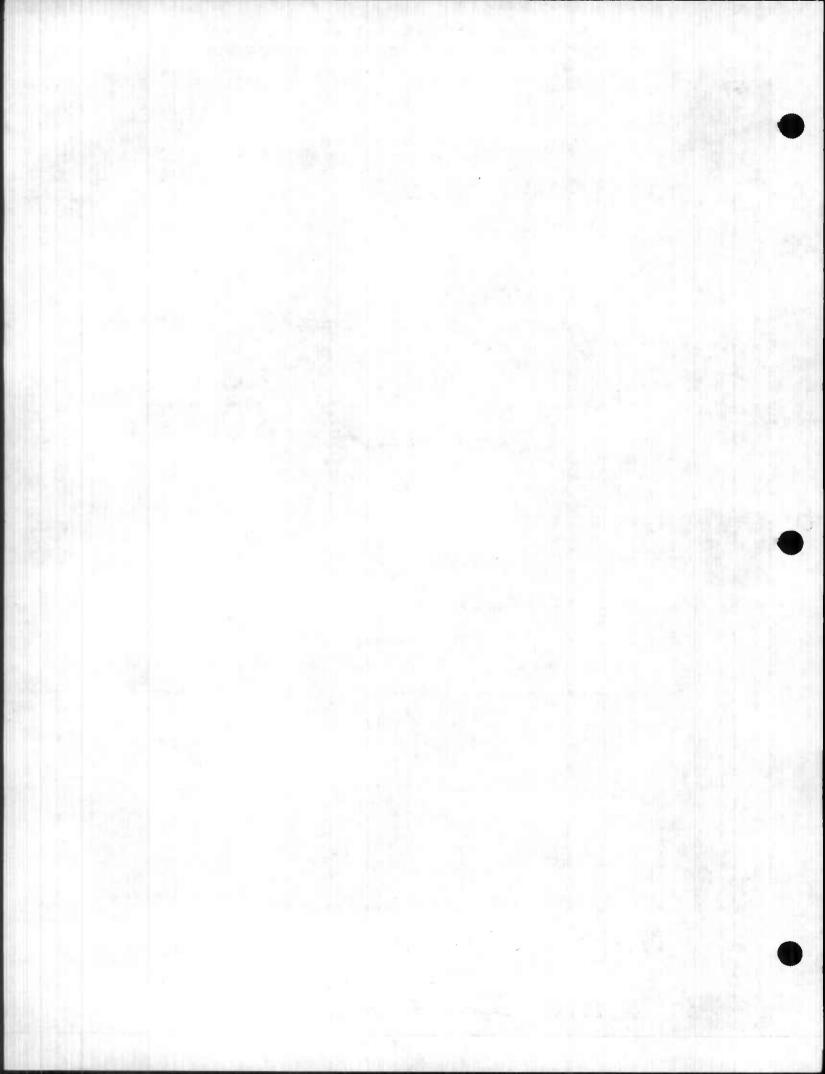
29c. License number

29d. Date signed (Month, Day, Year)



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State of Maryland /	Department o	f Health and M	ental Hygiene

					Oldio Ol	ivial ylai		rtificate				Reg. No.		C 3 4 0
		_	1. Decedent's Name	a (First, Middla, La	st)						2. Data of De	ath	Vana	3. Tima of Deeth
	Physician	_	Evelyn	Norris	Johnson	n					Decemb	er 15,	2000	1:30 pm
1	/Medica Examine		le Facility Nama (I	f not institution, giv	a street and numb	per)			4	b. City, Town, or	Location of Deat	-		
			4932 C	hestnut S	Street				- 1	Shadysi	ide	Anne		del
	Funeral		5. Social Security N	umber 6. S	Sex y 7.	Aga (In yrs.	last birthday	If Undar 1	Yaer Days	Hours Min	8. Deta of Bir	th ly. Year) 7, 1916	9. Birth	placa (Stata or Foreign
	Director		577-16-64	14	□M 2 F	8	4 Yrs.	WOTHING	Days	Tiours IVIII	Nov. 2	7, 1916	Ma	ryland
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	or 28a-f a		Maryland	Anne Arı	undel		Sh	adysid	_			10g. Citizen of	M# -1 O	
	with you	5	10e. Street and Nur					10f. Zip C		- ()				ntry r
	23 a	Louisia		hestnut S	12. Wes Deced	ent Eves le II	C 12	Was Doordon	_	764	Specify Vac or N	U.S.		can Indian,
	b me	5	11. Maritel Status	ad 2 Married	Armed Force	as?	,5. 13.	It Yas, specify	y Cuba	in, Maxican, Pue	Specify Yas or No rto Rican, atc.)	Bla	ick, White,	
36	a c.	D.	3 XWidowed		If Yas, Giva			1□Yes 2	No	Specify:		Speci	fy: W	hite
21215-0036	within 72 hours after deeth with the Maryland and "returel", or items 23e or 28e-f show the Medical Examinar must be northed a	2		15. Decedent's E			16e. Dece	edant's Usual (Occup	ation		16b. Kind of E		
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212	filed with Hygiene. ther than nnt, the	E	Elementery/Seco 12	ridary (0-12)	Collega (1-4	ioi 5+)	Tow	m Trea	sur	er			asant	
p	走工有 2	00	17. Father's Nama	(First, Middle, Last)					18. Mothar's Na	me (First, Middla	, Ma <i>ide</i> n Suma	ma)	
la	Mental Mental Brice every marked or	2	Alfre	d Norris	5					Mo11:	ie Gibb	5		
Maryland	2 should end Men le marke eumatic		19a. tntormant's Na	ame/Ralationship (Type, Print)		19b. Mail	ing Address (Straat	and Number or F	lural Routa Numb	er, City or Town	, Steta, Zi	p Code)
	1 and 2 Health e em 27 le		Dale J.	Johnson -	- Daughte	er	4932	Chest	nut	Street,	Shadys	ide, MD	207	64
Baltimore,	T S T S T S T S T S T S T S T S T S T S	-	20a. Mathod of Disp		70 0		Placa of Disponentary, cra	osition (Nama	a of ar plea	:e)	Data	20c. Location	- City or T	own, Stata
E	Peges net: If Its iry or o		4 Donetion	☐ Cremation 3 ☐ 5 ☐ Other (Specif	JHamovai from St		rt Min	coln C	eme	tery	12/19/00	Brentw	ood,	Maryland
alti	permit. Pege Department of Important: If any Injury or pace.	-	21. Signetura of Fu	peral Sarvice Licer	nsee ///	10.00	11/1	2. Nama and	Addre	ss of Facility			200	
0	50E 5 8		1	/-	1/11	- (/ G	asch's	Fu	neral Ho	ome, P.A	e etterili	lo M	D 20781
			23a. Part1. Enter 1	ha disease, or com	plicetions that cau	sed tha dael	h. Do not ar	ntar tha moda	of dyin	g, such es cardie	ac or raspiratory	orrest,	LE, FI	Approximete
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	/Medical		Immediata Causa (disease or conditio	(Final	Br	east C	ancer						1	16 Years
	Examiner		resulting in death)		a		or as a conse	equance ot):						TO TEATS
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	ificate be executed g physician and as the burial-transit		Sequentially list co	nditions,	b	Dua to (d	or as a conse	equenca of):						
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Box	deeth certifications at for use a	riiysiciaium			d				7.7					
	be of feet for the state of the	2	Part II. Other signif	Icant conditions of	contributing to dea	th but not ras	ulting in tha	underlying cau	usa giv	en in Part I.	23b. Dld	tobacco use c	ontribute	to the cause of death?
P.0	thet the detache										10	Yes 2X No	3 Pre	obably 4 Unknown
	as the sea	2												
ord	requires	3									24a. Was	s an autopsy ormed?	9	Vere autopsy tindings veilable prior to
9	has be	2	0.000										0	ompletion of causa death?
of Vital Records,	The law requir	5									10	Yas 2⊠ No	1	☐Yes 2☐ No
/Ita	ysician: The scentificate director, per		25. Wes casa rafar axaminer?	red to medical						26. Plece of De	eeth (Check only	ona)		
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n o	ng Ph her th meral		 Manner of Death Manner of Death Matural 	h 5 ☐ Pending	28e. Data of (Month,	Injury Dey Year)	28b. Time Injury	of 28	c. Injur Wor	y at k?	28d. Describe	how injury occu	irred	
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$\frac{3}{2}$	after death. Director: A		3 ☐ Suicida 4 ☐ Homicide	detarmined	28a. Placa o	f Injury - At h	oma, tarm, s fy)	traat, tactory,	office			(Street and Num wn, Stete)	ber or Ru	ral Route Number,
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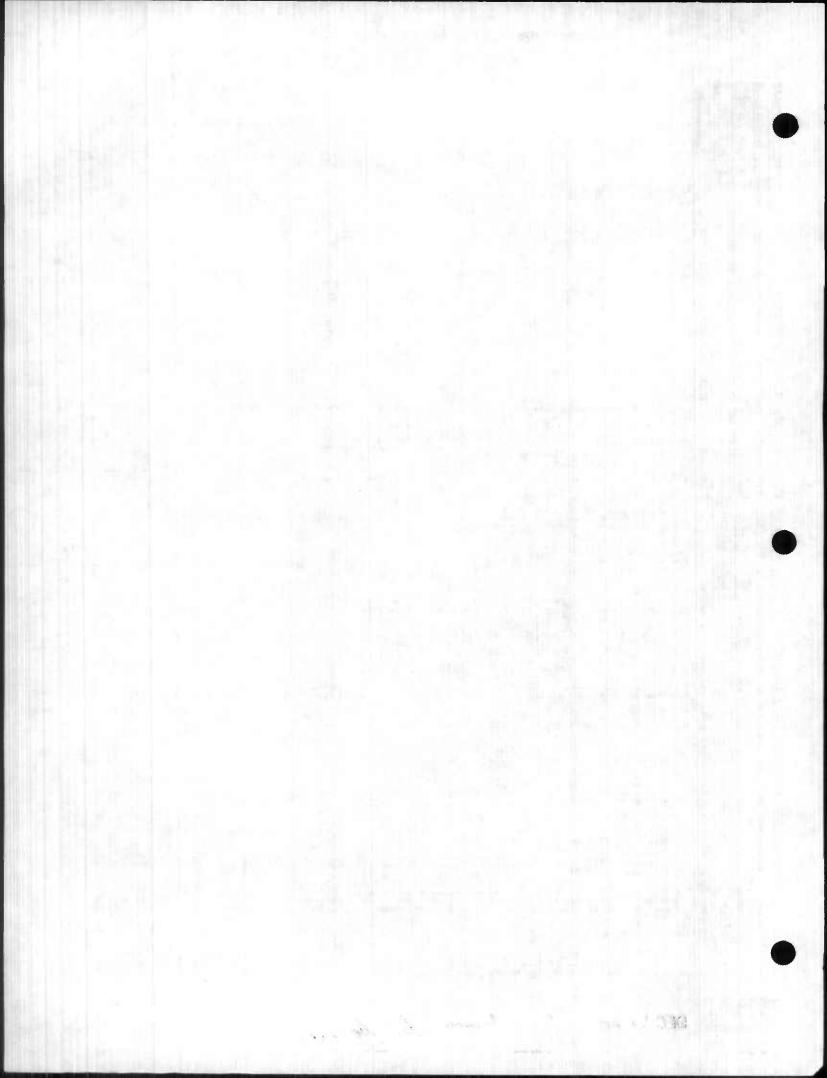
	Decedent's Nama (First, Middla, Last)			ete of Death	3. Time of Deeth							
Physician /Medical	Charles Bertram Kinch	DĔ	CEMBER 28,	2000 6:20AM								
Examiner	4e Fecility Neme (If not institution, give street and number)		4b. City, Town, or Location	of Death 4c. County	of Death							
	St. Mary's Hospital		Leonardtown		Mary's							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yet) 043−03−6225 1. M 2□ F	84 Yrs. If Undar 1 Yea Months Dey:	r If Undar 24 Hrs. 8. Do Hours Min. Jan	ete of Birth fonth, Day, Year) wary 25, 1916	9. Birthplaca (Stata or Foraig Country) New York							
D	Usual Residence of Decedent											
036 ours after death with the Meryland att, or ferme 28e or 28e-f show Example of the houthed a		City, Town or Location			10d. Inside City Limit							
or 289-1 a notified	Maryland St. Mary's	Bushwood			**							
Director Dir	10e. Street and Number	10f. Zip Code		10g. Citizen of V								
ath v	21235 Whites Neck Road	20618		U.S.A.	e - American Indian,							
\$ 25 p	11. Maritel Stetus 1 □ Nevar Marriad 2 ☒ Married 1. Wes Decedent Ever in Armed Forcas? 1 ☒ Yas 2 □ No	If Yes, specify Cu	Hispanic Origin? (Specify Y ban, Mexican, Puarto Rican	, etc.) Bled	ck, White, etc.							
Maryland 21215-0036 d 2 should be filed within 72 hours eff th and Mental Hygiene. 7 le marked other than "natural", or treumstic event, us Medical Exerc To Be Completed by F	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No	Specify:	Specify	White							
und 21215-0036 be filed within 72 hours effer lal hydiene. d other than 'natural', or he event, tre used a larger Be Completed by Fu	15. Decedent's Education	16a. Decedent's Usual Occ	upation	16b. Kind of Bu	usiness/Industry							
1 21215-0 ed within 72 ho sygiene. or than 'natur rt, to model	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)	16a. Decedent's Usual Occi (Give kind of work don life. DO NOT use retir	e during most of working ed)									
d with	10th	Operating Eng	gineer	Constru	action							
De file dothe event,	17. Fether's Nema (First, Middla, Last)		18. Mother's Neme (Firs	t, Middle, Meiden Sumem	10)							
Iryland 212: should be filed within should be filed within of Mental Hygiene. marked other than imatic event, the M	Samuel Kinch		Edith Lewi	S								
Aaryland 212 2 should be filed with and Mental Hygiene, le marked other the reumatic event, the To Be Comi	19e. Informent's Neme/Reletionship (Type, Print)		et end Number or Rural Rou									
ire, Maryland 21215-0-0 s 1 and 2 should be filed within 72 hc f Hault, and Merial hygiene, tiem 27 is marked other than "natur other traumatic event, the Medical To Be Completed	M. Lorraine Kinch (Spouse)	21235 Whites			4							
Ord Section of H	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State	 Plece of Disposition (Neme of cemetery, cremetory or other p 	ece) Da	Date 20c. Location - City or Town, Stete								
Pages ment of I	4 Donetion 5 Other (Specify)	harles Memorial	Gardens 12/	30/00 Leona	rdtown, Maryla							
Baltimore, Ma pernit. Pages 1 and 2 s Department of Haalth ar Important: if frem 27 le any injury or other treu ence.	21. Signeture of Funeral Sarvice Licensee	ineral Home	рΣ									
T	Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland											
	23a. Part1. Entar tha disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on aech line.											
Physician		Onset and Death										
/Medical Examiner	Immedieta Cause (Finel disease or condition	ocardial 9	nfarction	1	Lower							
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to box oof our is death cardificate be executed the ettending physician and hed for use as the burkel-fransit ysician/Medical Examir	resulting in death) Last Dua to	(or as a consequenca of):										
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dby the electrical strategies.	Pert II. Other algnificant conditions contributing to death but not in		Ivan in Part I.	23b. Did tobacco use co	ntributa to the cause of death 3 Probably 4 Unkno							
that that y	Diabety Me	llitus		1 108 20 NO	3 Probably 4 Officio							
ecords, P.O. By law requires that the death as been signed by the ette 2 should be deteched for npleted by Physicia				24e. Wes en eutopsy	24b. Were eutopsy findings							
shour should				performed?	evailable prior to completion of ceuse of death?							
The law requir sate has been single page 2 should			DATE:	1 □ Yes 2ANo	1 ☐ Yes 2 ☐ No							
vicien: The certificate irector, pag	25. Was case referred to medical		OC Bions of Doort (Ch		1 165 2 140							
OT VICAL INC Physicien: The la rithis certificate has ral director, page 2 T O Be Comp	exeminer?	□ ER/Outpatient 3□ DOA	26. Piece of Deeth (Che	5 ☐ Residence 6 ☐ Oth	ner (Specify)							
Physic crithis canadire and dire	27. Manner of Death 1 Defeature 28a. Dete of Injury (Month, Dey Year,			Describe how injury occur								
On odling After the fund	1 Neturel 5 Pending (Month, Day Year, 2 Accident investigation		ork? ☐ Yes 2 ☐ No									
Division of Vital Records, or attending Physician: The law requires the after daeth. Director: After this certificate has been signed in by the funeral director, page 2 should be deriffication: To Be Completed by	000000000000000000000000000000000000000	t home, ferm, street, fectory, offic	e 28f. L	ocation (Street and Numb	ber or Rurel Route Number,							
dinger of	Building, etc. (Speciny)											
Division or attending Phymerica 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	29e. Certifier (Check only one) 29e. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner a control of the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due end manner steted.											
he H in 24 he Fu	one) 2 Medical Examiner: On the basis of examinor one)	metion end/or investigation, in my	ориноп, аввит осситва вс									
M M	29b. Signature and titla of certifiar	29c. Lica	nsa number	1	d (Month, Day, Year)							
1	SCGaby 1	1D D	5 43 46	12/2	8/00							
you	30. Neme and address of person who completed cause of death (I											
[]		DLLYWOOD, MD. 20	0636									
State	31. Dete filed (Month, Dey, Year) DEC 2 2 2000											
Registrar	UEL YU MINI CZERGO	7 17										

State of Maryland / Department of Health and Mental Hygiene 00 42417

					Cei	rtifica	te of	Death			Reg. No.			
	- 3	1. Decedent's Name (First, Middle,	Last)							2. Dete of Dec			3. Time	of Death
Phy	ysician	Norman Fr	ank		Kraf	t				Month	Dey er 11,	Yeer	9.3	2 A.M.
	Medical	4e Facility Name (If not institution,		1	Ktai	_		4h City To	wn orl	ocation of Deeth			19:34	Z A.M.
Ex	aminer	St. Mary's Nurs												
190						W Hand	4 V	Leona				t. Ma		
Fun	eral		5. Sex 7. A 1⊠M 2□F	ge (In yrs. la		Months	er 1 Year Deys	If Under Hours		8. Dete of Birt (Month, De	h y, Year)	9. Birthr	place (Stantry)	te or Foreign
Dire	ctor	578-01-0828	165 M 201	80	Yrs.					March 2	4, 1920	Wash:	ingto	n, DC
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at of	1 1	10a. State 10b. County		TOG. City,	Town or Lo	Cation								City Limits
2 7	cto the	Maryland St.	Mary's	Pi	ney Po	oint							101	es 20 No
6 R	be notified Directo	10e. Street and Number				10f. Z	ip Code				10g. Citizen of	Whet Cour	ntry?	
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21215-0020 d within 72 hours at plens. r than "natural", or	Dy A	3 Widowed 4 Divorced	If Yes, Give Year or Detes:			1 🗆 Yes	2 No	Specify:			Specif	y: W]	hite	
P 10 0	W P	15. Decedent's	Education		16a. Dece	dent's Us	uet Occur	etion			16b. Kind of B	usiness/ir	dustry	
D 2 2	side side	(Specify only highest	grade completed)		(Give	kind of w	vork done	during mos	t of work	ring				
12 de la 12	Complete	Elementary/Secondary (0-12)	Cotlege (1-4or	5+)							Larr Enf	0.250.01	mont	
Per Per		12th Grade 17. Father's Name (First, Middle, L	not)		POL	rce (Offic		ar's Alam	e (First, Middle,	Law Enf		Henc	
d de de	Be s			77	C.									
Mer New Y	일 은	Norman	Andrew	Kr	aft			Etta		Mae		inkle:		
and an	5	19e. Informant's Name/Relationshi		-127						rel Route Number				
S part	is a	Mildred V. Kraf	t (Spouse)		P.0	. Box	x 3/,	Tall	Tin	bers, M	laryland	2069	90	
D - 1	6	20e. Method of Disposition		20b. Ple	metery, crei	sition (N	ame of	ce)		Dete	20c. Location	- City or Tr	own, Stete	
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1 11	2	21. Signeture of Funeral Service L		IL.	Linc			ss of Fecili		14/2000	Dieney	loou,	rial	rand
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		23e. Pert1. Enter the disease, or o shock, or heart failure. List o	omplications that cause	d the death.	Do not ent	ter the m	ode of dyir	ng, such es	cardiac	or respiretory e	rrest,	i	Approxir tnterval	mete Between
Physic	ian												Onset e	nd Deeth
/Med	ical	fmmediate Cause (Final disease or condition	P	2000	01	: 6	2 01	2				- 1	/ hr	el 1
Exami	iner	resulting in death)	a	Dunta/as	1 00	~~	0.			lare		1		cory
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BOX 68	× ×													
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dead dead	etached for us Physician/	Pert II. Other significant condition	s contributing to death	but not resul	Iting in the u	inderlying	cause giv	ven in Pert	f.	23b. Did	tobacco use co	ontribute 1	to the cau	se of death?
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as that as igned	y P													
lecords, P.O. law requires that the as been signed by th	d by									24a. Wes	en eutopsy			sy findings
COrdina v requira been sig	page 2 should										rmed?	CI	vailable pr ompletion	
dec law	CI DL											of	f death?	
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O E E	ret -	27. Manner of Death	28a. Date of In (Month, D		28b. Time o		28c. fnju Wo				how injury occu			
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OIVISION or Attending after death. Director: After	led in by the funera Certification:	3 Suicide 6 Could no	ot be One Diseased to	nium. At hor	me form et					28f Location (Street and Num	ber or Ru	rel Route i	Vumber
Or A sher	6 1	4 ☐ Homicide determin	28e. Ptece of tr building, e	njury - At hor otc. (Specify))	reot, lacti	ory, onice			City or To		00.00.00	011100101	
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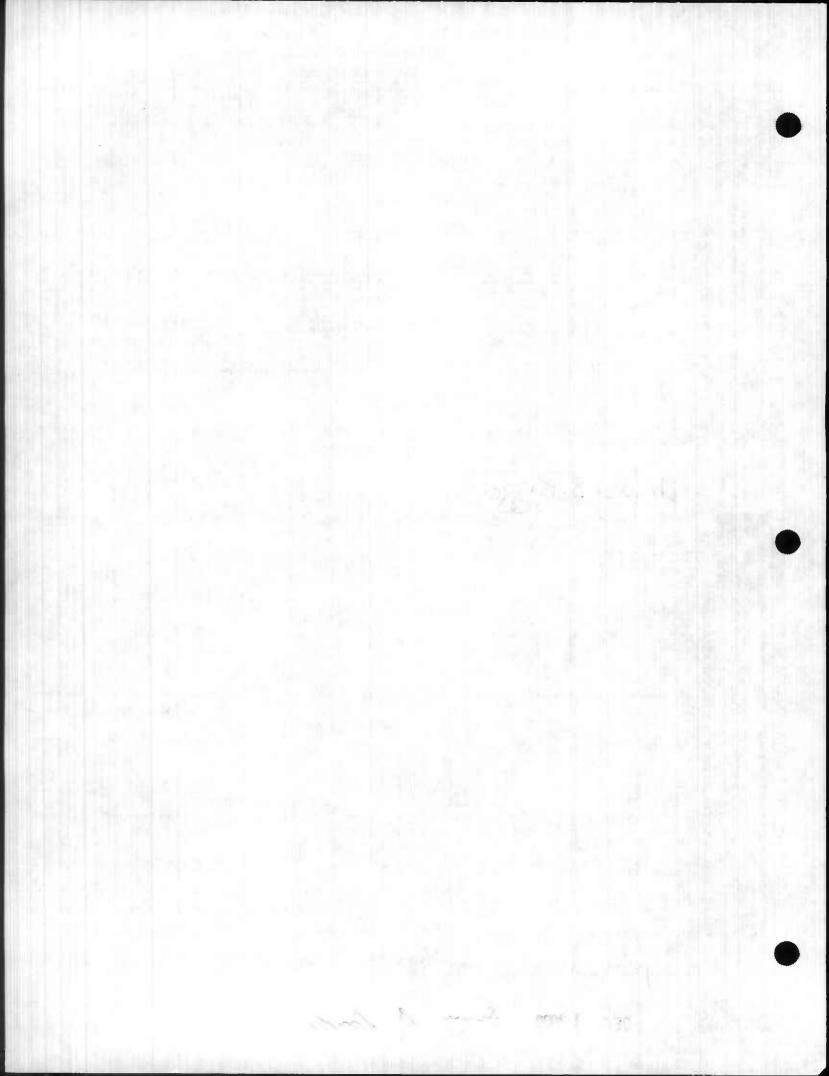
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State of Maryland / Department of Health and Mental Hygiene

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Trene Alexandrovna Kampf November 30, 2000 6:30 AM				Cei	rtificate	of De	eath		Reg	. No.		
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17. Familiar State State	Tanks Interest	15. Decedent's Ed	ucation	16e. Dece	dent's Usuel (Occupetio	on ring most	of working	16	b. Kind of Bu	siness/In	dustry
17. Father's Neme (Pirit, Mode, Lab) Maria Golybov	old Man			life.	DO NOT use	retired)	nig most	or working				
17. Father's Neme (Pirit, Mode, Lab) Maria Golybov	MAN TO			Но	memake	er				Ov	n Ho	me
Alexander Goronowsky See Informetic Share Selectionship (Prop. Pro) See Orge Kampf (Spouse) 200. Method of Disposition 18892 Russell Road, Valley Lee, Maryland 20692 200. Method of Disposition (Power and Property Selectionship) 201. Method of Disposition (Power and Property Selectionship) 202. Method of Disposition (Power Selectionship) 203. Method of Disposition (Power Selectionship) 204. Method of Disposition (Power Selectionship) 205. Method of Disposition (Power Selectionship) 206. Method of Disposition (Power Selectionship) 207. Method of Disposition (Power Selectionship) 208. Peace of Disposition (Power Selectionship) 208. Peace of Disposition (Power Selectionship) 208. Peace of Disposition (Power Selectionship) 208. Peace of Disposition (Power Selectionship) 208. Peace of Disposition (Power Selectionship) 208. Peace of Disposition (Power Selectionship) 208. Peace of Disposition (Power Selectionship) 208. Peace of Disposition (Power Selectionship) 208. Peace of Desire (Power Selectionship) 208. Peace of Desire (Power Selectionship) 208. Peace of Desire (Power Selectionship) 208. Peace of Desire (Power Selectionship) 208. Peace of Desire (Power Selectionship) 208. Peace of Desire (Power Selectionship) 208. Peace of Desire (Power Selectionship) 208. Peace of Desire (Power Selectionship) 208. Peace of Desire (Power Selectionship) 208. Peace of Desire (Power Selectionship) 209. Peace of		17. Fether's Neme (First, Middle, Last)				18	8. Mothe	r's Neme (Fir	rst, Middle, Ma	iden Sumem	e)	
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George Kampf (Spouse) 20b. Mandod of Disposition 10b Barial 2 Comention 3 Removal from Steel 11b Barial 2 Comentio	M M M			19b. Meiti	na Address (S	Street and	d Numbe	r or Rural Ro	oute Number. (City or Town.	Stete, Zit	Code)
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29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Dey, Year) 30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print) John Fenwick, MD State 29e. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 29c. License number 29d. Date signed (Month, Dey, Year) November 30, 2000 30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print) John Fenwick, MD Leonardtown, Maryland 20650 31. Dete filled (Month, Dey, Year) 32. Registrer's Signeture	After Fune	1 ⊠Naturel 5 ☐ Pending		Injury								
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	Funeral	5. Social Security Number 6. S	ex 7. Age (In yrs. la □ M 2∏ F 83	st birthday) If Under 1 Yes Wonths Day		8. Date of Birt (Month, Da)	, Year)	9. Birthpla Country	ce (State or Foreign y)		
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	Physician	23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death									
	/Medical Examiner	Immediate Cause (Final disease or condition	· Pre	unonla				iu	introun		
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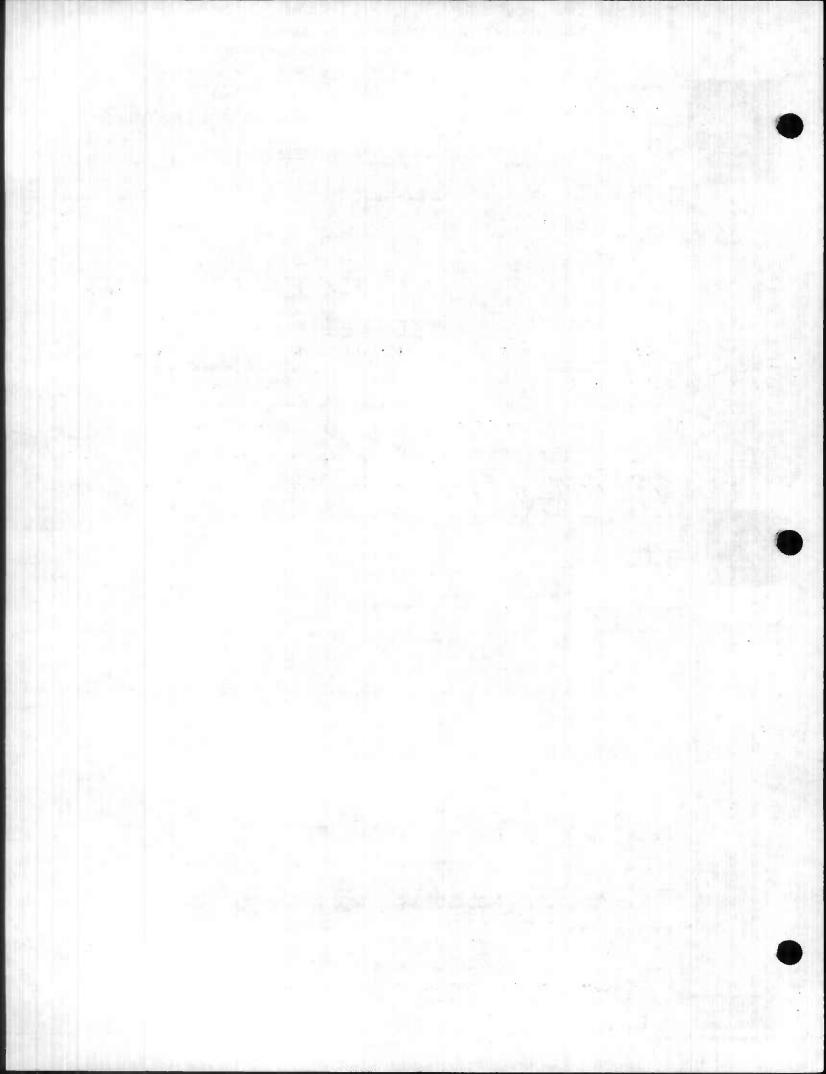
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death Physician Manuel Edward Kane December 17, 2000 /Medical 8:45 P.M. 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Daeth 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's 5. Social Sacurity Number if Under 1 Year | If Under 24 Hrs. 7. Aga (In vrs. last birthday) Funeral 8. Data of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Deys XXM 2□ F Months Hours 577 20 7289 Yrs. Director 80 Nov. 13, 1920 Fairfax, Virginia Usual Rasidance of Dacadan 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas ⊋ ☐ No Director Maryland Anne Arundel Annapolis 10a. Straat and Number 10f. Zip Code 10g. Citizan of Whet Country? Items 23a 2608 Rigging Drive 21401 Funeral United States 12. Was Decedant Evar in U,S. Armed Forcas? 1 ⊈Yes 2 □ No If Yes, Giva Yaar or Dates: WWI] Was Decedant of Hispanic Orlgin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Navar Marrlad 2 ☑ Married marked other than "natural", or 1 ☐ Yas 2 ☐ No Specify: WWII by 3 ☐ Widowed 4 ☐ Divorcad White Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) D.C. Police Elementary/Secondary (0-12) Collega (1-4or 5+) Hygiene. Department Policeman 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be and Mantal James E. Kane Ida F. Shanholtz Amit. Pages 1 end 2 shu In entmant of Haalth and Incortant: If Item 27 is m any injury or other traum once. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores McIntyre Kane Wife 2608 Rigging Drive Annapolis Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 19, 2000 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Waldorf Maryland The Huntt Crematory 22 Name and Addrass of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onsat and Daath **Physician** /Medical PHEUMONIA Immediate Causa (Final disaase or condition rasulting in death) Examiner Dua to (or es e consaquance of): Examiner that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initioted avants rasulting in daath) Last and Due to (or as a consequence of): Physician/Medical the Dua to (or es e consaquance of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? KIDNEY MASS, WEIGHT LOSS, 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of ceuse of death? HYPERTENSION DIMBETES HELLITUS Completed 24a. Was an autopsy parformed? ALTHEIMERS 1 Yas 2 No 1 Yas 2 No 25. Was cesa rafarred to medical axaminar? Be 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1□ Yas 2⊟No to the Hospital or Attanding Privitin 24 hours efter death.

To the Funaral Director: After the Ampletaly filled in by the funeral 28a. Data of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Tima of 28c. injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homleide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a. Cartifiar Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 18/00

Box 68760

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Records.

Vital

of

Division

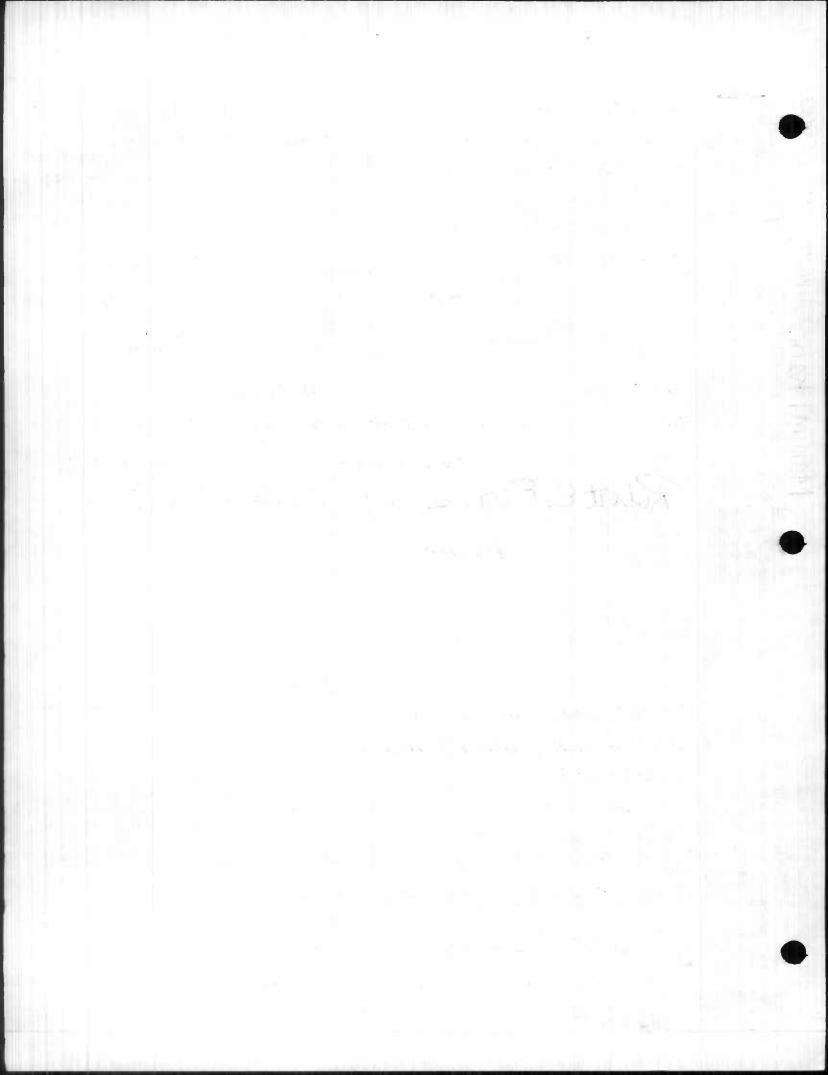
31. Data filed (Month, Day, Year) State Registrar

DEC 2 0 2000

30. Name and addrass of parson who completed cause of death (Itam 23a) (Type, Print)

FULTON MUBBEN MAD, 32. Ragistrar's Signature

CHUH CALARCOTTE HALL, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 42452

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ADMEND ITEM: #1 PER PHY G793 3-14-01 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death MARY MARGARET WILLIAMS KELLEY Month Year **Physician** Mary Margaret Williams KELLEY December 12, 2000 6:00 a.m. /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 5360 Solomons Island Road Huntingtown Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□M 2X F 73 579 40 0315 Yrs. Mar. 7, 1927 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a, Stete 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show ad call Examiner must be notified at Calvert Huntingtown 1 Yes ZANo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5360 Solomons Island Road 20639 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Reca - American Indien, Black White etc. 72 hours efter 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd 2 should be filed within 72 sith end Mentel Hygiene.
27 is marked other than "nu fraumatic event, my med Elementery/Secondary (0-12) College (1-4or 5+) accountant retail drug store 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: If flow 27 is marked other any Injury or other traumatic event ables. Clarence Edward Helen Elizabeth Young Philips 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) William H. Kelley (husb.) same as 10 above 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stale 12-15-00 Lakemont Mem. Gardens Davidsonville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Rausch Funeral Home, Owings, MD Part. Enter the disease or complications that grid set the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Me aroma MONTH Immediate Ceuse (Finel disease or condition resulting In deeth) /Medical Examiner Due to (or es e consequenca of): Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initieted events resulting in death) Last Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy parformed? Completed certificate hes b irector, pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No edical Certification: To this 27. Menner of Deeth 28d. Describe how injury occurred To the Mospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completaly filled in by the funera 28c. Injury et Work? Division 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

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State Registrar

29a. Certifier

29b. Signeture end title of certifier

1 M1 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture DEC 1 3 2000 Gener

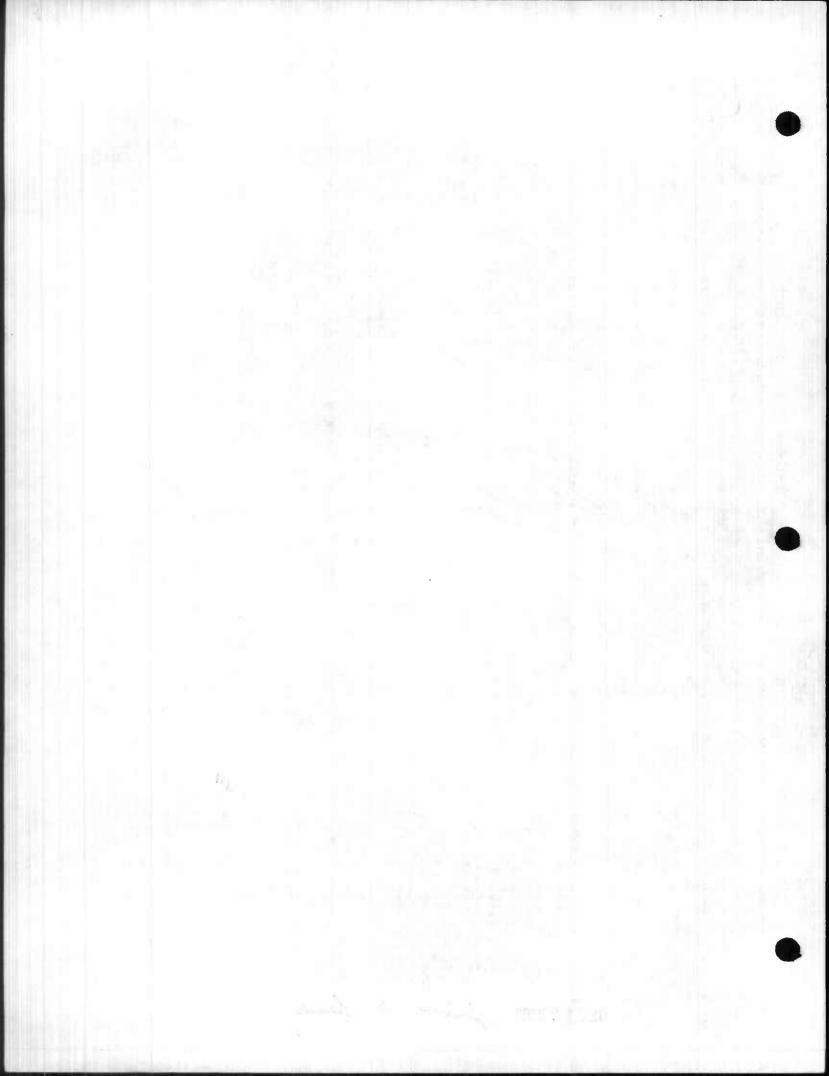
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tacket, Prince Ardenick, MD 20678

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.

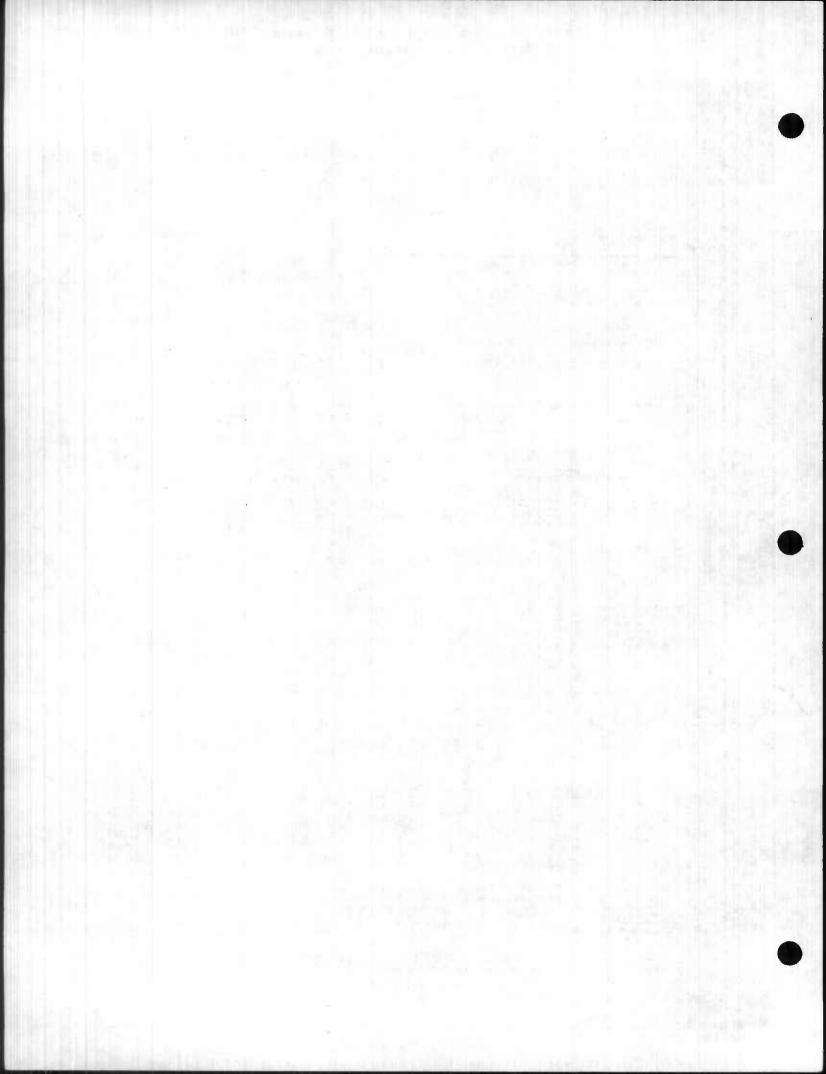
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29d. Date signed (Month, Dey, Year)

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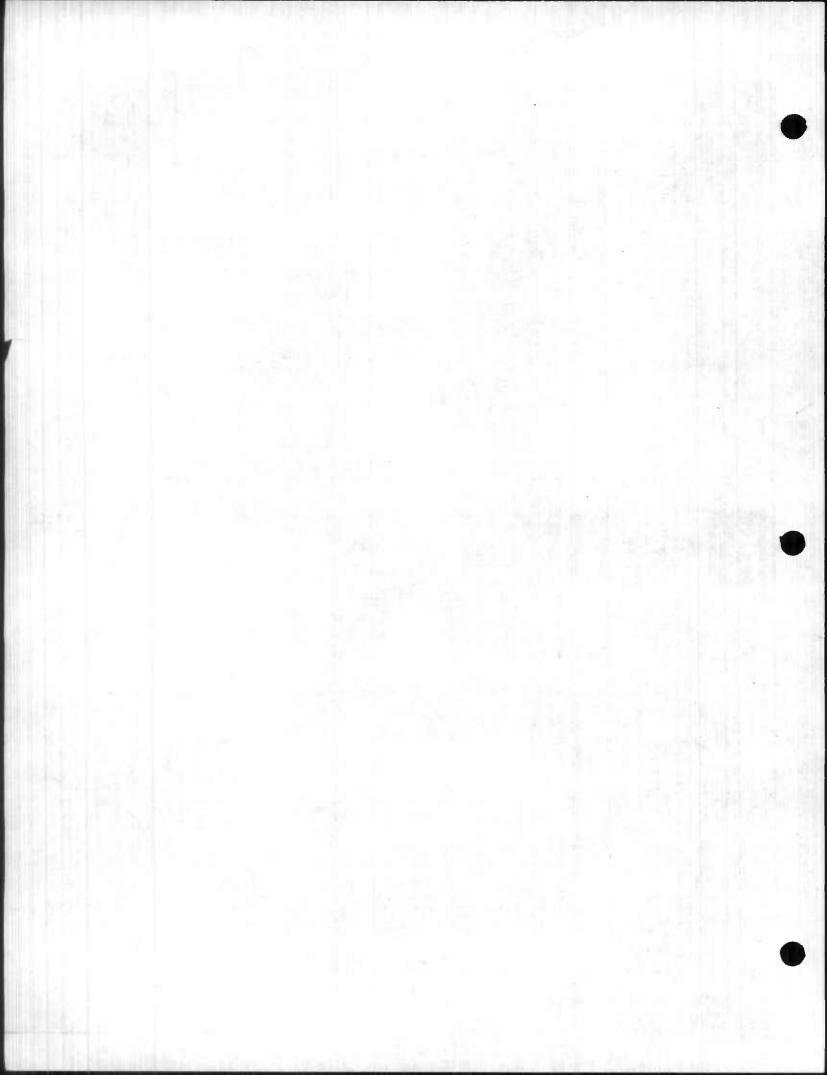
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED, Item 10e, (per F.H.) TCHD, 12/12/00, sbb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear **Physician** KATWERINE 5. KIRBY 10:46 AM 12 10 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER TRANMA BATIMORE SWOW BALTIMONIE If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sax 7. Age (In yrs. last birthday) **Funeral** 1 M 20hF Months Days Yrs 224-16-8358 09/25/ Director Usual Residence of Decedent 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 □ No BASTON TALBUT MD 10e. Street and Number 501 Dutchmans Lane 10g. Citizen of What Country? 10f. Zip Code 늄 Examiner must be a USA ONTCHLAND LANG 21601 Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WWITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SECRETARY EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) pes 1 and 2 should be fit of Health and Mental H 7 fem 27 is marked off CLAUDE WILSON JORDAN VIOLET WATSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) DAVIS C. KIRBY, JR./ HUSBAND 501 DUTCHMANS LANE, EASTON, MD 21601 20b. Placa of Disposition (Name of cematery, crematory or other placa) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 12-12-00 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata rval Beh Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Honns a MASSIVE MIGHT INTHAPPARENCHMAL Examiner WEM ORNWAGE Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be asscuted Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 6 3 Probably 4 ☐ Unknown by Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? has 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth Certification: 580 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident 8 Could not be determined Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital To the Hospital within 24 hours a To the Funeral completely filled 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner es stated. edical 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Himone, Mi) 21201 BAKER South Greene Ellene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 2 2000 Geneva Registrar done **DHMH 16 Rev 6/95 ORIGINAL**



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month Year **Physician** 15:10 Bernard N. LaFate 12 00 24 /Medical 4c. County of Deeth 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Clinton Prince George Southern Medical Center If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthplace (Stete or Foreign Country) 7. Age (In vrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys 120 M 2□ F 222-10-5359 Director Wilm., DE Usual Residence of Decedent 10d Inside City Limits 10a State 10h County 10c. City. Town or Location 12 Yes 2 □ No NewCastle Pear 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code USA 19701 20 Airdrie Dr. Funer 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Stetus Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: black 3 □ Widowed 4 ₺ Divorced by 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) tamsportation State of Delaware 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) should be marked Thomas LaFate Lillian (Williams) LaFate 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Jandre LaFate 20 Airdrie Dr. Pear, DE 19701 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Delaware Veterans Mem. Ceme. 12-29-00 21. Signature of Purera Service License 22. Name and Address of Facility
The House of Wright Mortuary P.O.Box 447 Wilm., DE 19899 23a. Pert1. Enter the disease, or complications that have the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or hear failure. List only one cause of much line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical pancytopenia Examiner Due to (or as e consequence of): Ca-cinon Examin physician and the burial-transit the deeth certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medicai Due to (or es e consequenca of): 88 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 s atate, Bernard 1 Yes 2 No 1 Yes 2 No certificate 25. Wes case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, term, street, tactory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as steted. 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number Rointy Frank M.D. 12,25,00 10+1VA 30. Name end address of parson who completed cause of death (Item 23e) (Type, Print) suit 3-35 SiLVER SPRING MD 20902 9801 Georgia Ave ROINTAN FARAHI FAL 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registra Sparks DEC 2 6 2000

ORIGINAL

DHMH 16 Ray 6/95



Director:

28a. Date of Injury (Month, Dey 27. Manner of Death 1 Neturel 5 Pending 2 Accident

investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 □ Yes

2 No

28d. Describe how injury occurred Subject 1201 28f. Location (Street end Number or Rurel Route Number, City or Jown, Steje)

Adelson U6 /

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

HONE

29d. Date signed (Month, Dey, Year)

O.C.M.E.

December 18, 2000

se and address of person who completed cause of death (Item 23a) (Type, Print)

J. Laron Locke M.D.

4 | Homicide

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical

31. Date filed (Month, Da 32. Registrer's Signature 22 2000

To the Hospital of within 24 hours at To the Funeral D

Bost called &.

Seed to the

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month **Physician** William E. Likens December 20, 2000 5:10 a.m. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (ff not institution, giva street and number) 4c. County of Deeth Examiner Sunbridge Care & Rehab. Elkton Cecil If Undar 1 Yaar | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) Dec. 31, 1 9. Birthplece (Stata or Foreign Country)
Virginia 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Months Hours 1X M 2 F Yrs. 74 1925 223-32-5893 Director Usuel Residence of Decedent with the Meryland 10d. Insida City Limits 10e Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director Cecil Maryland Rising Sun 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Lot #3 Sun Valley Circle USA 21911 Peges 1 and 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiena.

Mint: If item 27 is marked other than "natural", or Itema 23 any or other traumatic event, fire and call Event or many or other traumatic event, fire and call Event or many or other traumatic event, fire and call Event or many or other traumatic event, fire and call Event or many or other traumatic event, fire and call Event or many or other traumatic event, fire and call Event or many or other traumatic event, fire and call the call th 14. Race - American Indian, Bleck, White, atc. 12. Was Decedant Evar in U.S. Armed Forces? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced Yaer or Detes White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Maintenance Worker Retail Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) William Jake Likens Bertha Honaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Bessie Taylor/Sister PO Box 304 Christiansburg, VA 24068 Baltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or othar plece) 20c. Location - City or Town, Stata 20e. Method of Disposition Date 1 ☐ Burial 2 Cremetion 3 ☐ Removal from Stete Depentment of important: if any injury or pace. R. A. Ferris & Co., Inc. 12-22-00 West Chester, PA 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Address of Fecility 21. Signature of Funerel Service Licens R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911 itions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, to cause on each line. Approximete Interval Between Onsat and Daath ease, or compliance. List only on Physician Months Immediate Ceuse (Final disease or condition resulting in death) /Medical Lung with Metastasis Examiner Physician/Medical Examiner years The law requires that the death certificate be executed the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest and Box 68760, attending physicien Due to (or as e consequenca of): 28 esu P.0. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not rasulting in tha underlying cause given in Pert I. signed by 1 Ves 2 No 3 Probably 4 Unknown of Vital Records, Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? page 2 should 24a. Wes an eutopsy performed' 1 Yes 2 12 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred Division After 5 Pending investigation 1 Neturel aftar death. 1 Yas 2 No 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and manner stated. 29a Certifier completaly 29b. Signeture and titla of pertifier 29d. Date signad (Month, Day, Year) 29c. Licansa number Sachelev S. MD 12.20,2000

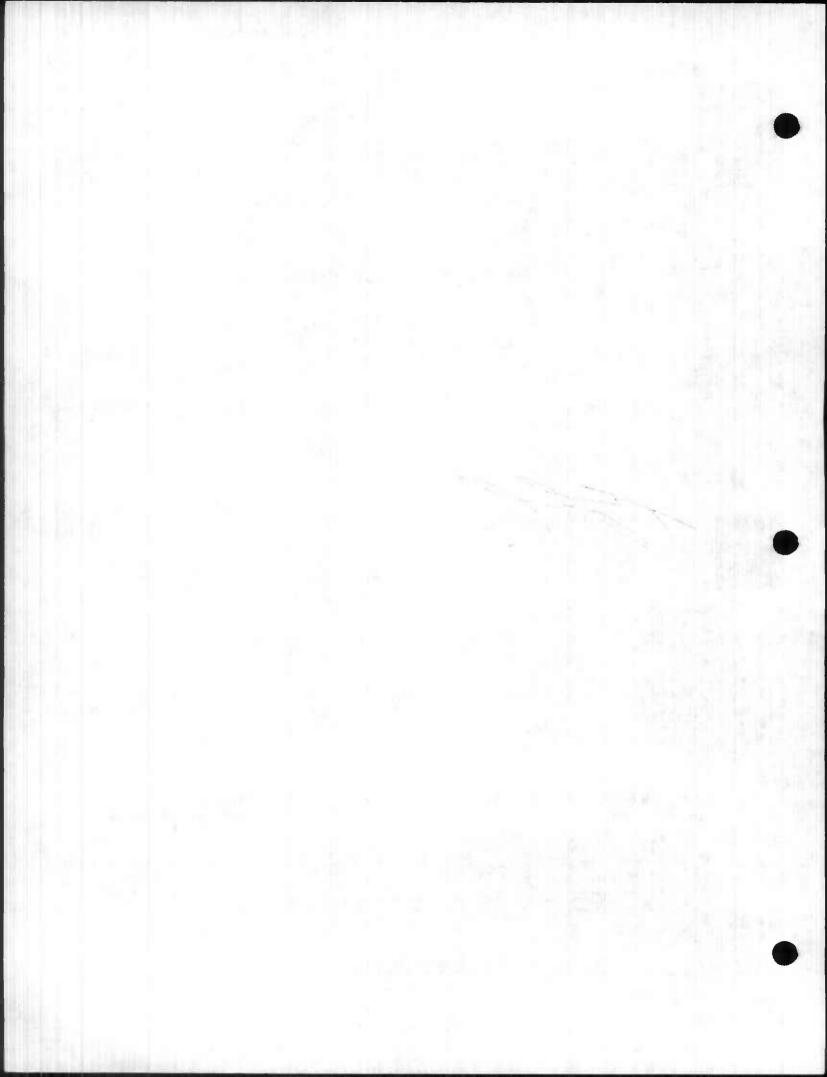
DHMH 16 Rev 6/95

State Registrar . S. SACHDEN MD, 118 North St, Suite 3B, Elbton MD 21921.

30. Nema end address of person who completed cause of death (Item 23a) (Type, Print)

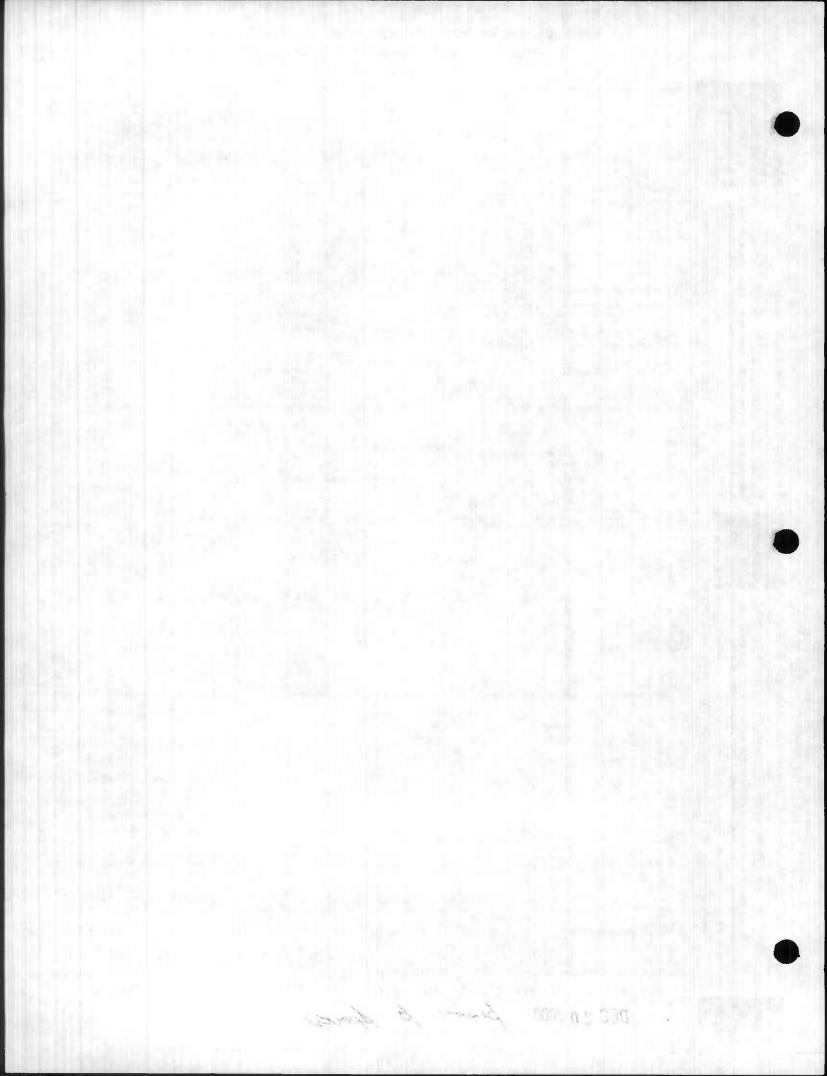
32. Registrar's Signature

31. Dete filed (Month, Dey, Year)



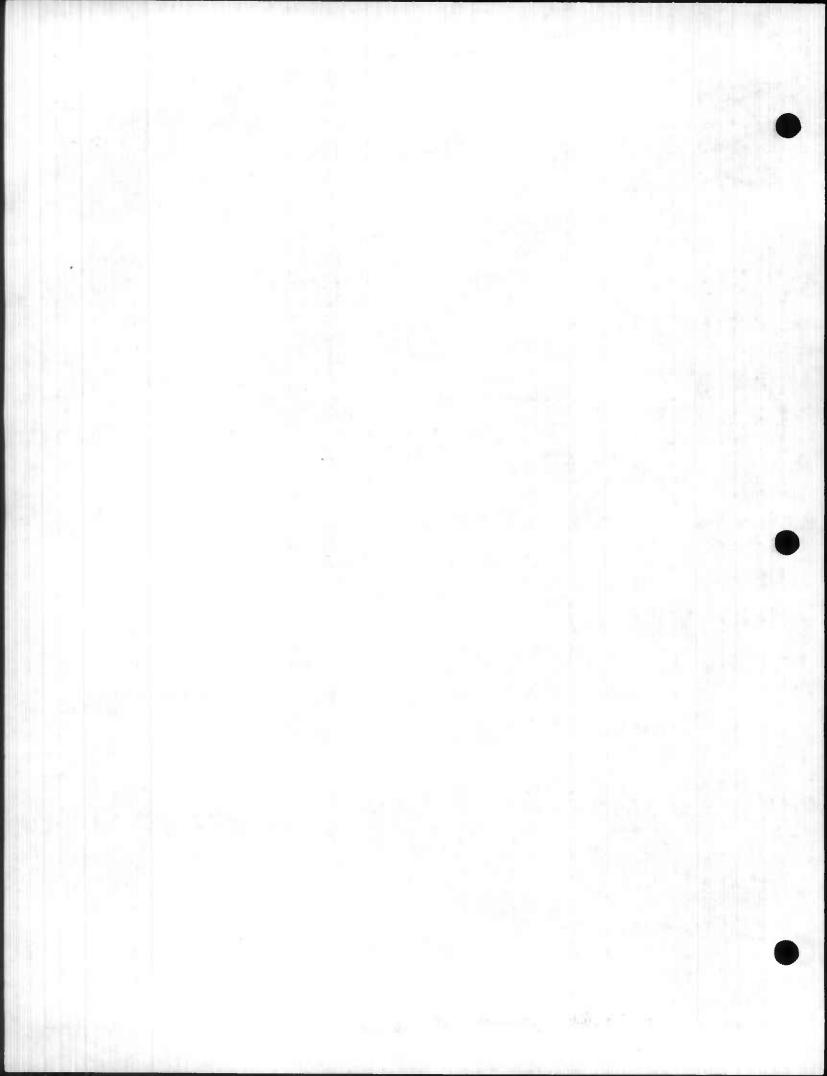
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	State of Maryland / Department of Certificate	of Death Reg. No.
Physician	1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month Day Yeer S December 15 2000 1516
/Medical	BILLY WARRIE LECATE 4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Deeth 4c. County of Deeth
	PENINSULA REGIONAL MEDICAL CENTER	
Funeral Director	213-24-1876 73 Yrs.	Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country) AUG. 17, 1927 DELMAR, DE
and **	Usual Residence of Decedent 10a. Stele 10b. County 10c. City, Town or Location	10d. Inside City Limits
with the Maryland a or 28a-f show Le notified at Director	DELAWARE SUSSEX SELBYVILLE	1 □ Yes 2 🕅 No
ith the Ma or 28a-f	10e. Street and Number 10f. Zip Co	10g. Citizen of What Country?
e 23e		975 USA tt of Hispanic Origin? (Specify Yes or No. 14. Rece - American Indian,
and 21215-0020 be filed within 72 hours after deeth viel Hygiene. d other than "natural", or heme 23 avent, the Weddel Evanther must avent, the Meddel Evanther must Re Completed by Funeral	1 Never Married 2 Merried 1 Yes 2 No	Cuban, Mexican, Puerto Ricen, etc.) Black, White, etc.
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Maryland 2 d 2 should be filed th and Morel Hygi T is marked other traumatic avent, I	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S	Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Haalth		338, SELBYVILLE, DELAWARE 19975
normal plants	1 🛱 Burial 2 □ Cremation 3 □ Removal from State cemetery, cremetory or other	er place)
ortens Political	4 Ocnation 5 Other (Specify) BISHOPVILLE CE	METERY 12/19/00 BISHOPVILLE, MD Address of Facility
Ball Department of the part of	111111111	FUNERAL HOME, SELBYVILLE, DE. 19975
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Physician /Medical	1	Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	treng Disease
	Due to (or as e consequence of):	Fren Discie
\$8760, cate be assented physician and s the burist-transit	Sequentially list conditions, Due to (or es a consequence of):	The first of
8760, cate be axecuted by sicien and the buriel-transi	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury	
6876(ficate be physicie as the burn	resulting in death) Last Due to (or as e consequence of):	
P.O. Box 6 at the death certific dby the ettending etteched for use as	d	
D. B.	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Pert I. 23b. Dld tobacco use contribute to the cause of death
P.C.		1 □ Yes 2 □ No 3 □ Probebly 4 ☑ Unknow
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Of V Of V Physical ribis control of ribi	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)
ang P Bing P Affert funeration:	Eleatoral of a storing	: Injury et 28d. Describe how injury occurred Work? 1 □ Yes 2 □ No
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To the To the Domple	29b. Signetyre and title of certifier 29c. I	icense number 29d. Date signed (Month, Day, Year)
GNIK	Mona	34768 12/15/00
9,18	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	to Complete 1503 C SAUSBUR
State	31. Dete filed (Month, Dey/Year) 32. Registrer's Signature	2180
Registrar	DEC 2 0 2000 Serve B. Sp.	all!



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miner	1330		rnot institution, gi erless A	iva street and num	nber)			Upper Ma		th 4c. County Prince		rge's
		Social Security N			7. Age (In yrs.	last birthday)	If Undar 1 Year	If Under 24 Hrs.	8. Data of Bi (Month, D			lace (State or Forai
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Director	10e	. Street and Nur	mber				10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?
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Funeral	11.	Marital Status		12. Was Dece		J,S. 13. V	Vas Decedent of I	Hispanic Origin? (Span, Mexicen, Puert	pecify Yes or No Rican, etc.)	o- 14. Raci	e - Americ	
by		1 Never Marri 3 Widowed	ied 2 Married 4 Divorced	1 🗆 Yes If Yes, Give Year or Da	2 No		☐ Yes 2 No				Blac	
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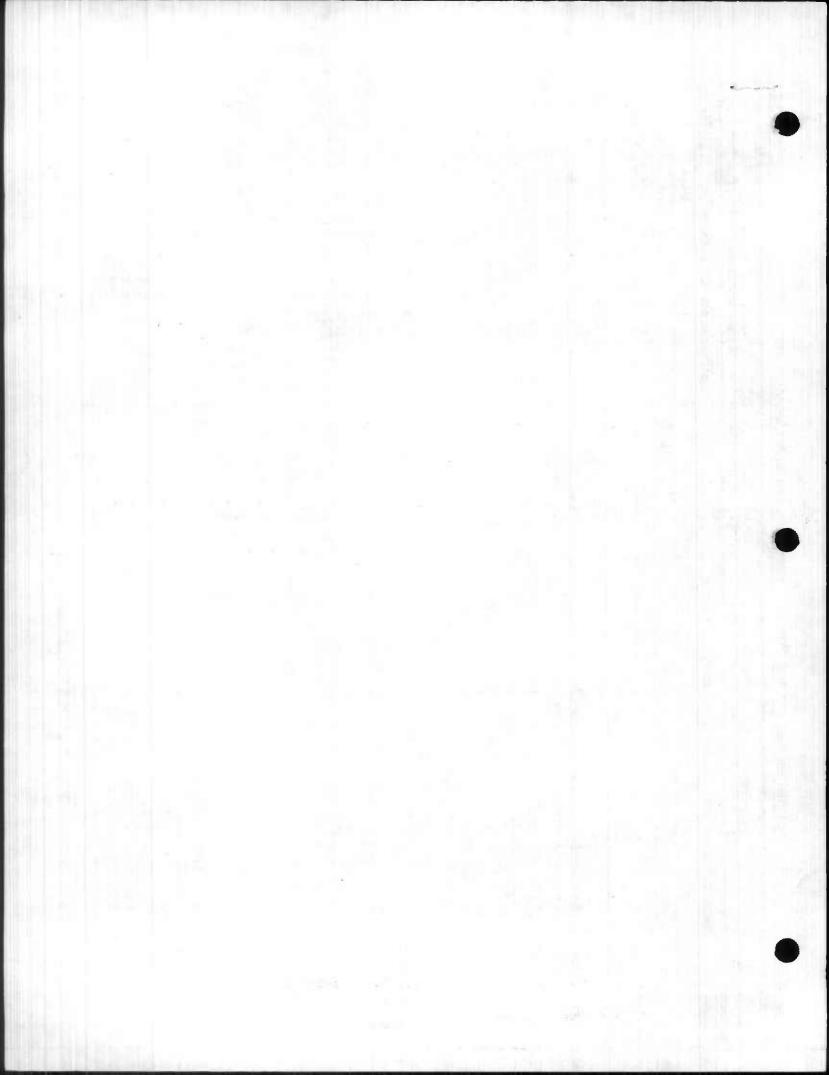


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State of Maryland / Department of Health and Mental Hygiene 0 0 42460

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #26 PER PHY G791 1-20-01 WR. Certificate of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician** 02:15 am Katharine Wright Leap Dec. 19 2000 /Medical 4a Facility Name (If not instifution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1405 School St. Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 10 1903 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1□M 2MF Yrs 97 Maryland 215-38-1961 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Dorchester Cambridge 23a or 25a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? à 501 Radiance Drive 21613 U.S.A. 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 matural, or 1 Yes 2 No Specify: Specify: white 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nit. Pages 1 and 2 should be artment of Health and Mental ortant. If them 27 is marked of Daniel Henry Wright George Ruth Brown 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David W. Leap - son 1405 School St., Cambridge, MD 21613 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 20a. Method of Disposition 1 Burla1 2 ☐ Cremation 3 ☐ Removal from State Dorchester Memorial Park 12 - 21Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home, PA 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RTEP-63CLEROTIC CAMMOVASCULAR SEVENAR
DISCASE YEARS **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Yss 2 No 3 Probably 4 Unknown ela Valcular Decidon by Division of Vital Records, 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24a. Wes en eutopsy Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) RESIDENCE Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 10 1 Yes 2 No this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Menner of Death 28b. Time of Certification: After or Attending W Natural 5 Pending after death. Director: Aft 1 Yas 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifier 29c. License number 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

Registrar

Mahmood Shariff,

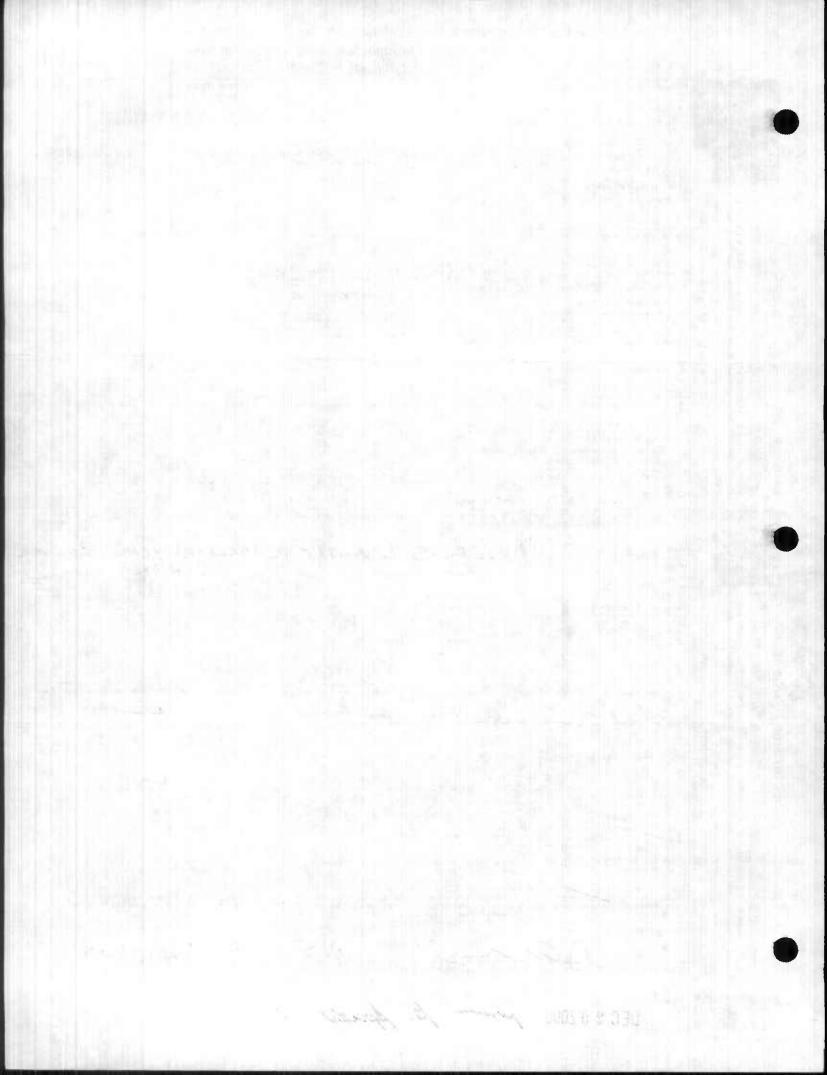
DEC 2 0 2000

31. Dete filed (Month, Day, Year)

MD

32. Registrer's Signeture

105 Aurora St., Cambridge, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Joor **Physician** :15 PM ANICE /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HEARTLAND OF HYATTSVILLE HYATTSVILLE PRINCE GEORGES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Dey, Yeer) 1 ☐ M 200 F Months Days Hours 267-53-8328 Director 40 OCT. 19,1960 FLORIDA Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits an "natural", or Items 23s or 28s-f show Medical Examiner must be notified at Director 1 Yes 2 No PRINCE GEORGES HYATTSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 703 CHILLUM RD. #201 20783 death Funeral U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Rece - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married Married Yes 2 No f Yes, Give 1 ☐ Yes 2 No Specify: py Specify: 3 ☐ Widowed 4 ☐ Divorcad Year or Dates: BLACK Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 12 CASHIER FOOD SERVICE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumeme) . Peges 1 end 2 should be fill mant of Health and Mental Hant: If Item 27 is marked oth jury or other traumatic even 2 BRAND MARY FRANCIS 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) WELDON W. LOCHE/HUSBAND SAME AS #10 ITEM 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removel from State permit. Pege Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 12/8/00 RIVERDALE, MD. 21. Signature of Funeral Service Ligania 22. Name end Address of Fecility 5801 CLEVELAND AVE. rancus M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner The law requires that the death certificete be executed bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest pue Due to (or es a consequence of): physiclan Physician/Medical the Due to (or es e consequence of): USB dateched for Pert II. Other elgnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? eta has been signed by pege 2 should be dated 1□ Yes 2☑No 3 ☐ Probably 4 ☐ Unknown p Completed 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? this certificeta 1 ☐ Yes 1 Yes 20 No I or Attending Physician: " after death.

Director: After this certifice director, 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) 20 Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Yeer) funeral Certification: 27. Mamner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigetion Neturel 2 Accident 1 Yes 2 No the 3 ☐ Suicide 6 Could not be determined To the Hospital or Attention 24 hours after de To the Funeral Directo completaly filled in by the 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

Medical

29s. Certifier

29b. Sig

n who completed cause of deeth (Item 23e) (Type, Print) legistrar's Signeture

29d. Date signed (Month, Dey, Yeer)

00

Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted.

29c. License number

3

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O.

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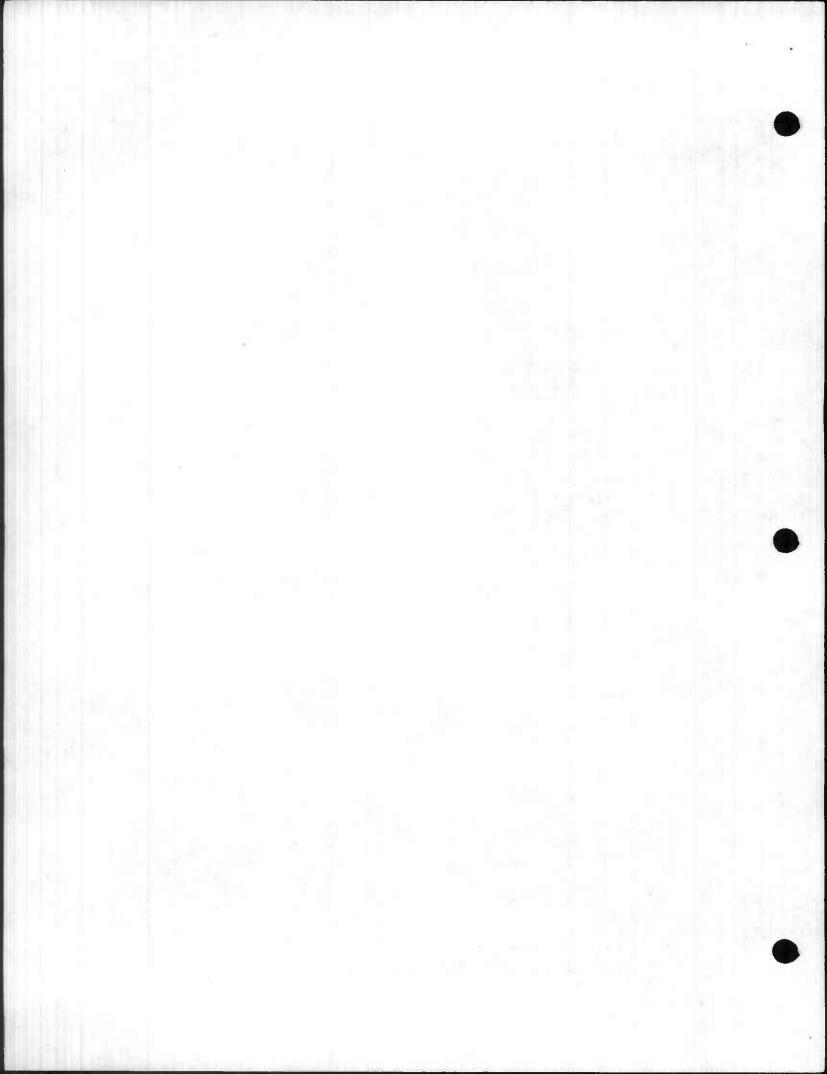
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Lines 28b. & 28d. WCHD/SC/12-18-00

State of Maryland / Department of Health and Mental Hygiene

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Funeral Director		5. Social Security Number 212-08-0212	6. Sex 1 [™] M 2□ F	7. Age (in	yrs. last birti		If Undar Months	1 Year Days	If Under:	24 Hrs. Min.	8. Dete of Bir Month, Da Feb I	in (1969	9. Birth Cou Pen:	plece (Stentry) nSylv	ete or Foreign 7ania
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with the	Funeral Director	10e. Street and Number	e Road				10f. Zip	Code 217	22	9		10g. Citizen of U.S.		ntry?	
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To the Hospital or Attending Physician: The lew requires to within 24 Hours after deeth. To the Funeral Director: After this certificate has been signed completally filled in by the funeral director, page 2 should be a	Certification:	1 Neturel 5 Pending investige Suicide 6 Could no determin	ot be 28e. Piac built	ca of injury - ding, etc. (S	Unkn At home, far		М	1 🗆	Yes 2	No	City or To	Street end Nur			
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To the within To the compl	Me	29b. Signature and the of certifiar			no				se number	2	PR K	29d. Dete sign			
		00. Name and address of person w	ho completed cau	use of deeth	(Item 23a) (Type P	rint)	.60-	m.///	IRI	or k	ASSESSE C	TRAICH	, ,	~



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 42464 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3 Time of Death December 25, 2000 **Physician** David Myers 23:00 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c County of Deeth Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1₩ M 2□ F Deys Yrs. October 4, 1946 Indiana 262-76-9085 54 Director Usual Residence of Decedent the Marylend r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TNNo Directo Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Examiner must be 21680 Alalanta Street 20653 USA permit. Peges 1 and 2 should be filed within 72 hours after death vaccent ment of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or items 23, any injury or other traumatic event, the Medical Example mans Funerai 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Grade Logistics Analyst Defense Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) John Fred Myers Agnes Maloney 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 653 19e. Informent's Neme/Reletionship (Type, Print) Patricia R. Myers (Spouse) 21680 Alalanta Street, Lexington PArk, Maryland 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Charles Memorial Gardens12/30/2000 Leonardtown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Du Edward N. Brinsfield, JR. M00052 P.O. Box 279, Leonardtown, Maryland 20650 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Examiner and I-transit tha daath certificata be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physician ar s the burial-t Physician/Medicai Due to (or as a consequence of). 80 attending for use es signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown thet Division of Vital Records, ò 24b. Were autopsy findings eveileble prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? certificate has b director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: T s eftar daath. Il Director: After this certificet ed in by the funeral director, p 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☑ No To 1-Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or within 24 hours eff To the Funeral DI completaly filled in 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medicai 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of 9 29c. License number 29d. Date signed (Month, Day, Year)

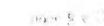
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30. Name end eddress of person who comp

32. Registrar's Signeture

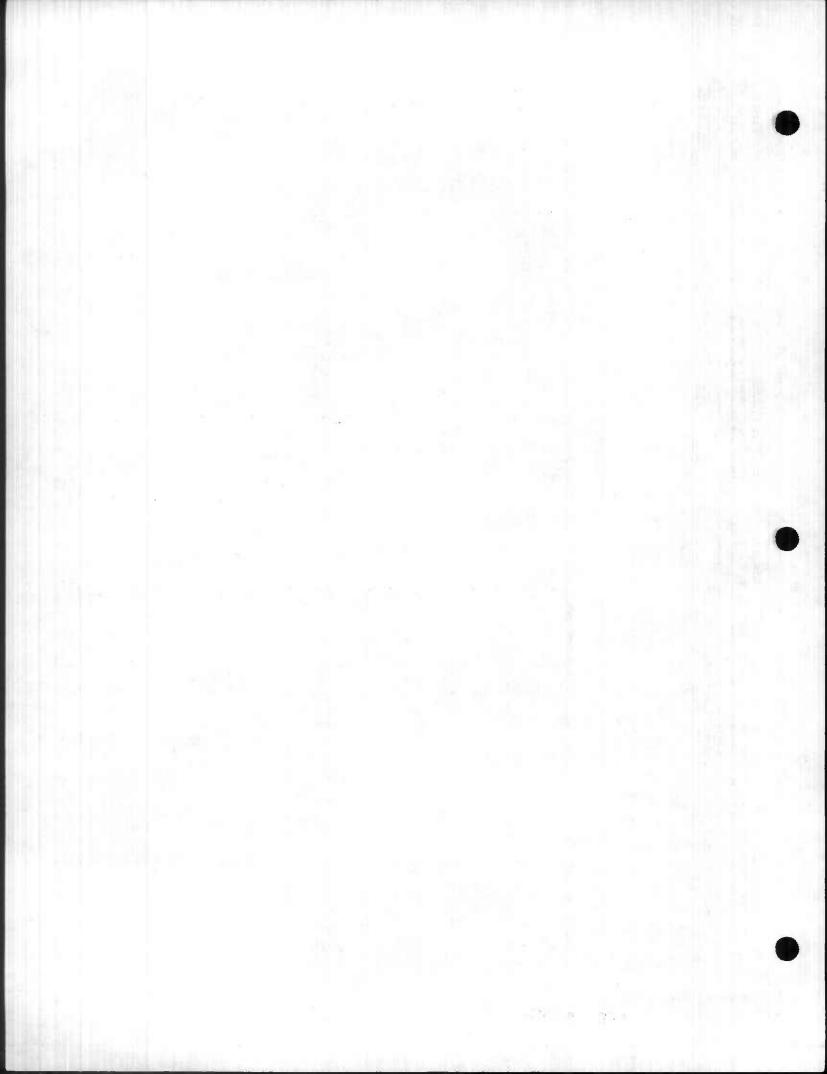
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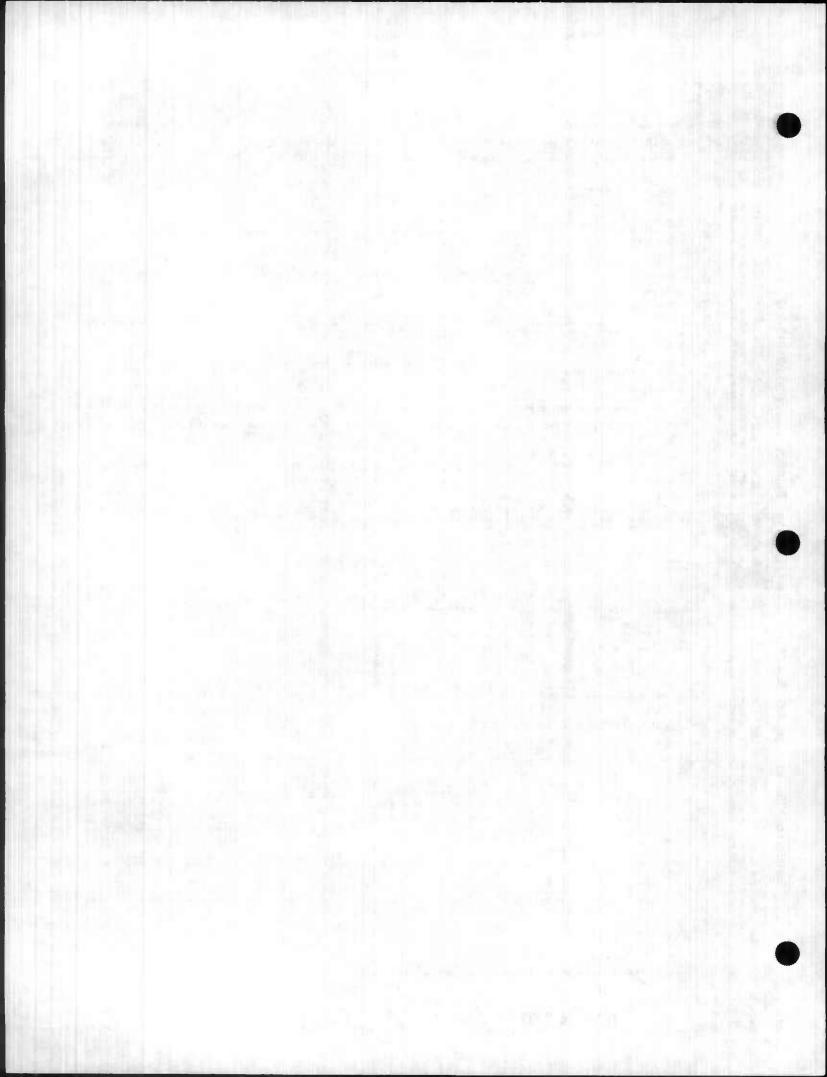
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-	Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs.	8. Date of Birth (Month, Day,)		plece (Stete or Foreign intry)
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Ba	Deport Management of the Post	21. Signature of Funeral Service Licensee Mary B. Rizzo Molly? 22. Name and Address of Fecility Brinsfield Funeral 22955 Hollywood Roa			20650 ryland
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ā	tal or Attending P is after death. al Director: After t ied in by tha funare Certification:	4 Homicide building, etc. (Specify)	City of Youri,	Siele)	
	A fille	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place	, end due to the cau	ise(s) and menner es	stated.
	To the Hospital or Attending Phi within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funarei Medical Certification: 7	(Check only and/or investigation, in my opinion, death occurrence) (Check only and/or investigation, in my opinion, death occurrence)	rred et the time, dat	e end place, and due	to the ceuse(s)
	Nithin Somp	29b. Signeture end title of certifier 29c. License number	29	d. Date signed (Month	n, Day, Year)
	, ,,,	1 19917		12/5/00	
				17 3/00	
_	^	DR. AMES BOYD CALIFORNIA, MD. 20619			
V		31. Data filed (Month, Day, Year) 32. Registrar's Signeture			
	State	coco harman			
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STEVEN MATTHEWS-BULL



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					Cer	tificat	e of	Death			Reg. No.			
	33	1. Decedent's Name (First, Middle,	ast)							2. Date of De		V	3. Tim	e of Death
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/Medi		4a Facility Nama (If not institution, g			DI.		-	b. City, To	wn, or Lo	ocation of Deal				
Examir	ier .	39845 Wrinkle F					1	eona	rdto	47D	St N	Mary'	9	
				Age (In vrs. la:	st hirthday)	If Unda		If Undar				-		ate or Foreign
Funeral			100 M 2□ F			Months		Hours	Min.	8. Data of Bi (Month, D	ay, Year)	Coun	ntry)	
Director		214-12-7890 Usual Residence of Decedent		79						Januar	y 17, 1921	. Ma	ryla	.na
pu »		10a. State 10b. County		10c. City.	Town or Lo	cation						1	Od. Insid	le City Limits
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₹ 6 E	Directo	10e. Street and Number				10f. Zip					10g. Citizen of \		itry?	
£23a		39845 Wrinkle	Free Lane			2	20650)			U.S.A	<i>A</i> •		
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d within 72 hours after giene. ir than "natural", or fte ir the Modes E in		1 Nevar Married 2 Married	1 X Yes 2					Specify:		,			010.	
urs urs	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giva Yaar or Date	es:		1 1 1 1 1 2 5	ZIXINO	Specify.			Specify	· V	White	2
72 hours "natural",	ted	15. Decedent's	Education		16a. Deced	dent's Usu	el Occup	ation			16b. Kind of B	usiness/In	dustry	
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should be and Mental I marked or	70			gry, or		an Address	. /Ct-o.ot				ber, City or Town,		Code	
		19a. Informant's Name/Relationship				•								'EO
Health fem 27 other tr		Doris Kathleen	Mattingly					tie Fre	e Lan		ardtown, M			
0 7 2 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from Str	CAL	nce of Dispo	natory or	me or othar plac	ce)	i	Date	20c. Location -	City or 10	wn, Stati	0
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		shock, or heart feilure. List or	ly one cause on eac	h line.	DO HOL BIT	er tre mo	20 OI Gyii	ig, suon as	Cordiac	or respiratory	a1103t,	1	Intervel	Between and Death
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/Medical Examiner	20	Immediate Cause (Final disease or condition	a cardi	s mho	you	aven	+					- 1	mil	As
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	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	28b. Time of Injury	1	28c. Injui Wo	rk?		28d. Describe	how injury occu	red		
Attending or death. ector: After by the fune	at	2 Accident investige				М	1	Yes 2	No					
	Certification:	3 Suicida 6 Could no 4 Homicide determine	ad 286. Place of	Injury - At hon, etc. (Specify)	ne, farm, str	reet, factor	y, office				(Street and Num.	ber or Run	al Routa	Number,
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State of Maryland / Department of Health and Mental Hygiene

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uneral		5. Sociel Security Number 194-10-1931	6. Sex 1 🔀 M 2 🗆 F		s. lest birthday) Yrs.	Months 1	Deys	If Under Hours	Min.	8. Date of Bi (Month, D	rth ey, Yeer)	9. Birth	place (Stete or Fountry)
rector	-	Usual Residence of Decedent		00						1/6/1	912		PA
show	- 1	10a. State 10b. Count	у	10c. 0	City, Town or Lo	ocation							10d. Inside City Li
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or 28a-f	Funeral Director	10e. Street end Number			305	10f. Zip C						n of What Cou	intry?
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		20e. Method of Disposition			Piece of Dispo	osition (Neme	e of	a)		Date	20c. Loca	tion - City or T	own, State
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death December 19, 2000 **Physician** 1:50 AM MINNIER /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WICOMICO NURSING HOME SALISBURY WICOMICO If Under 1 Yeer | If Under 24 Hrs. 8. Dala of Birth (Month, Day, Yea MAY 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Days Hours NEW YORK 1□M 2K)F Months Yes 85 1915 210-16-2649 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Menyler Hydions. Wher than "natural", or items 23e or 28e-f show ent, the Medical Essenties ment to modified a N Yas 2 No Directo SALISBURY MARYLAND WICOMICO 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 900 BOOTH ST U.S.A. 21801 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Biack, Whita, etc. 1 ☐ Yas 2 No If Yes, Giva 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2 No Specify: Specify. 2 3X Widowed 4 Divorced Year or Detes: WHITE Completed 16e. Decedent's Usuel Occupation
(Giva kind of work dona during most of working
lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) pemili. Peges 1 and 2 should be filed will Department of Health and Mental Hyglen important: If Itan 27 is marked other that any Injury or other treasment. HOMEMAKER OWN HOME Maryland 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) UNKNOWN 8 HENRY HARRINGTON 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) ELLA R. SHOCKLEY - DAUGHTER 514 HAMMOND ST SALISBURY, MD 21804 more. 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 12/19/00 4 ☐ Donation 5 ☐ Other (Specify) CAMBRIDGE CREMATORY CAMBRIDGE, MARYLAND 21. Signatura of Funaral Service Licenses 22. Nama and Addrass of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC.

23a. Part1. Entar the disease, or complications that caused tha deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona cause on aach lina. SALISBURY, MD 21804 Approximata Interval Between Onset and Death **Physician** tmmediata Causa (Finel diseasa or condition rasulting in death) /Medical Examiner Examiner burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as e consequance of pug physician s the burial Box 68760 certificate be Physician/Medical Dua to (or es a consequance of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Julmary Lucau Records, by 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No eronary letter 1 ☐ Yas 2 No Vital Be 25. Was casa refarred in medical examinar? 26. Piaca of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 1 Yas 2 No o 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred Certification: Sion Attanding 5 Pending 1 Natural tnjury death. 1 Yas 2 No Diractor: / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) after 4 Homicide 6 To the Hospital o within 24 hours af To the Funeral Di completely filled is edicai 152 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and titla of certifier 29d. Date signed (Month, Day, Year) 29c. Licensa number (100 2DQ 50. Nama and odrass of person who completed cause of death (Itam 23a) (Type, Print) 21801 BELLOSO, M. D. REGORIO 5302 CHINABERRY DR., SALISBURY, MD

Registrar **DHMH 16 Rev 6/95**

State

31. Dete filed (Month, Day, Year)

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32. Registrar's Signetura

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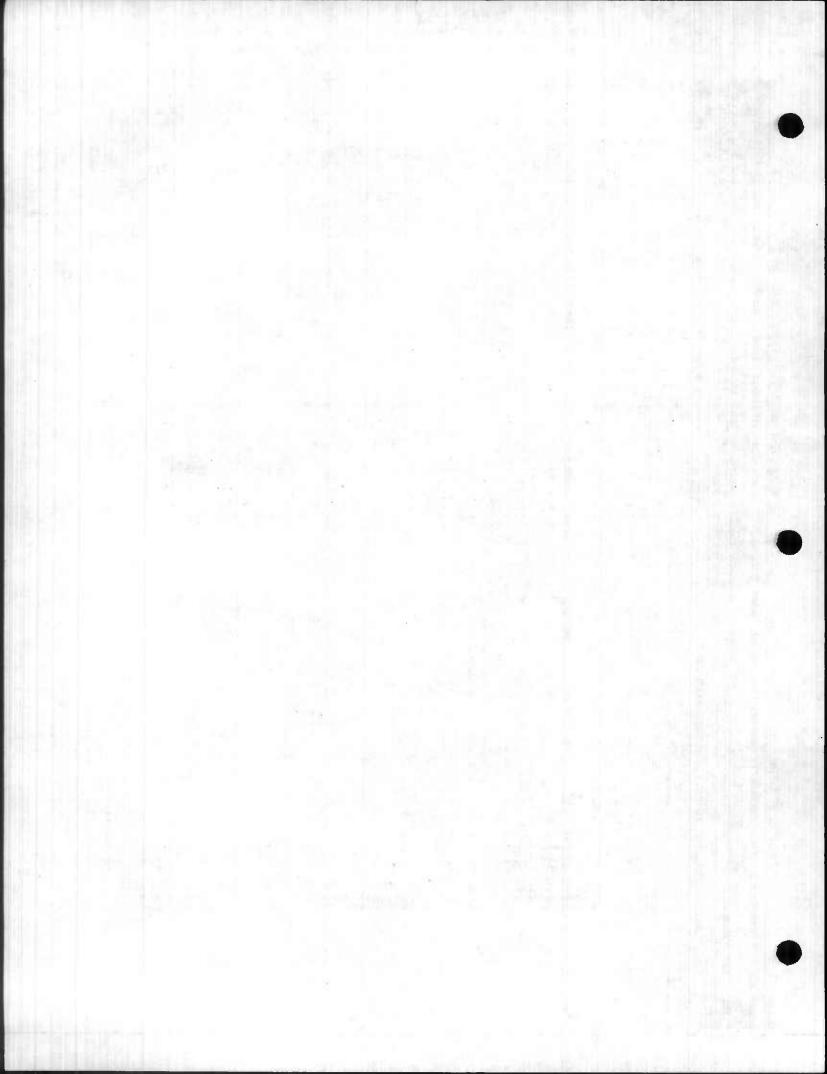
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth December Dey Year **Physician** Verla Marie Mangum 5 20:10 ,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Elkton Union Hospital 8. Date of Birth (Month, Dey, Year)
June 9, 1915 If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year 9. Birthpleca (Stete or Foreign **Funeral** Months Days Hours Min. 1 M 2 KF West Virginia Yrs. 578-26-5672 85 Director Usual Residence of Decedent the Meryland 10c. City, Town or Location 10e. Stete 10b. County 10d. fnside City Limits d 2 should be filed within 72 hours efter deeth with the Menyler hand Mental Hyglene.
I la marked other than "natural", or florer 23a or 28a-f show traumatic event, the Medical Example manufactorized. 1 Yes 2 No Maryland Cecil Risina Sun Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 9 Ridge Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: by If Yes, Give Year or Detes: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Telephone Operator Communication 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) mit. Pages 1 and 2 should be filt partment of Heelth and Mental H portant: If Item 27 Is marked oth y injury or other traumatic even Maynie Pearl Neil Arnon Lee Cutlip 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Mary Cutlip Martin/Sister 9 Ridge Rd., Rising Sun, MD 21911 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any injury or page. 4 ☐ Donetion 5 ☐ Other (Specify) Shenandoah Cemeteru 112-11-00 Winchester, Virginia R. T. Foard Funeral Home, P. A. 21. Signature of Furieral Service Licensee 111 S. Queen St., Rising Sun, MD 21911 die uchard Part Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiretory errest, show, or heart fellure. List only one cause of each many control of the seath many control Approximete Intervel Between Onset end Death **Physician** Respiratory Arrest Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Minutes Examiner Examine neumonia ettending physicien end for use as the burial-transit that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events Due to (or es a consequence of): Exacerbation Records, P.O. Box 68760. Physician/Medical Due to (or es a consequenca of): resulting in death) Last LOPD Years Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributs to the cause of death? ed by the e signed by I 1 Yes 2 No 3 Probably 4 Unknown Contusion due to Fall þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed s certificate has t director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner?

102 Yes 2 No Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27 Menner of Deeth 28b. Time of Injury Certification: 28c. Injury et Work? After or Attending 1 Netural 5 Pending investigation 1 Yes 2 No tell at nursing home deeth. Dec 2, 2000 un known I Director: A 250 Accident 28e. Place of Injury - At home, form, street, factory, office building, etc. (Specify)

Calvut Manor Nur Sing Hume 281. Location (Street end Number or Aurel Route Number. M) City or Town, Stete) 1881 Telegraph RL, Rising Sun 6 Could not be determined 3 ☐ Suicide 4 | Homicide after To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner as stated. edicai 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ternos, 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Union Hospital, Elkton, Farkas 31. Dete filed (Month, Dey, Year) DEC 2 0 2000 Registrar

DHMH 16 Rev 6/95

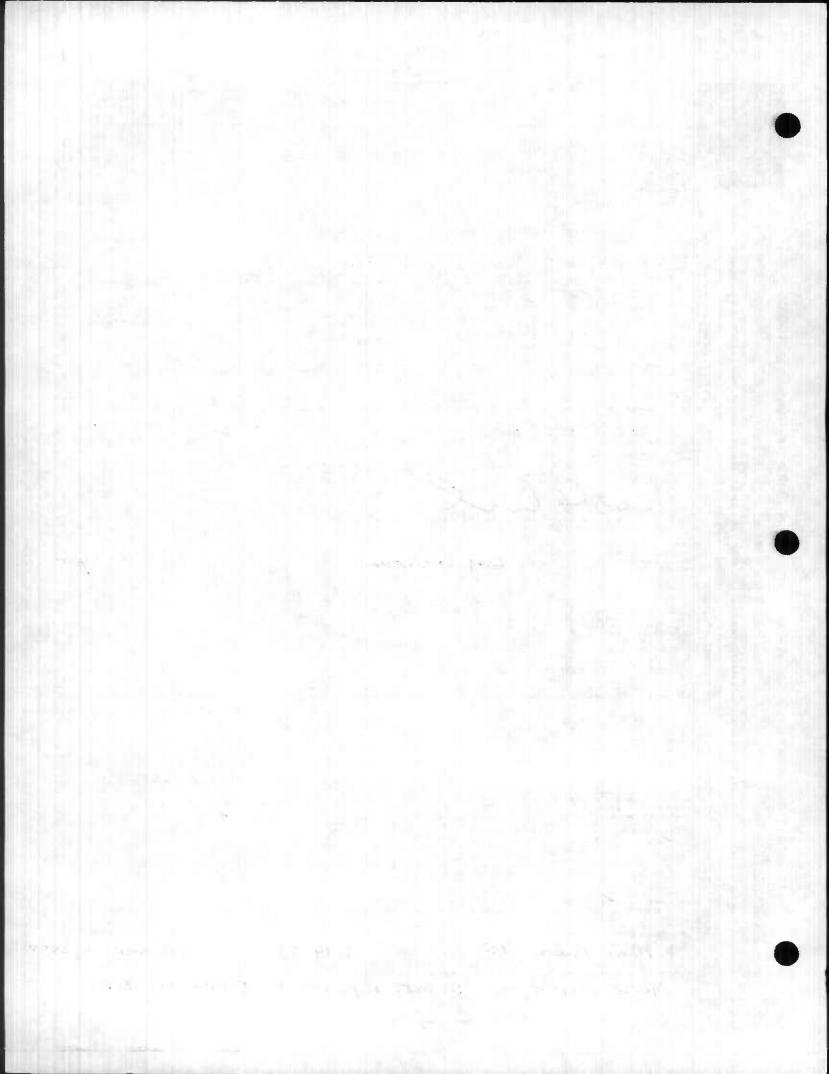
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	29b. Signature and title of Monte 30. Name and address of	I certifier Maß person who	completed cause	e of death (Ite	m 23a) (Type,	Print)	D 447	183	ELKTO	Decen		•
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	s that the	cate has been signed by the attendir page 2 should be detached for use Combleted by PhysicianA							1 🗆 Y	2 XNo	3 Probably	4 Unknow
	Division of Vital Records, P.O. Box or Attending Physician: The law requires that the death cer after death. Director: After this certificate has been signed by the attending in by the tuneral director, page 2 should be deteched for use					Tell (24a. Wes a perform	n autopsy ned?	avallable	utopsy findings o prior to ion of ceuse ?
	E .	certificate has rector, page 2				Britan			1 🗆 Y	es No	1 ☐ Yes	2□ No
	Vita	ector Be	25. Wes case referred to medicel examiner?	Hospital:			O	her	th (Check only or			
	Of	this all dir	1 Yes 2 No	1 L Inpatier		R/Outpatient 3 28b. Time of	DUA	4 U Nursing H	ome 5 Z Reside	-		
	Sion ending	or: After the fune cation	1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	00		Injury M		Yes 2 No				
	Divi	ed in by	4 Homicide determined	28e. Place of Inju- building, etc	ry - At hom . (Specify)	e, ferm, street, fact	ory, office		28f. Location (Si City or Town		per of Hurel Flou	re <i>Number</i> ,
	he Hospital	To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hyeician: To the best o miner: On the basis of end manner sta	examinetio	edge, deeth occurre n and/or investigati	ed at the toon, in my	ime, date and plece opinion, deeth occu	, end due to the c rred at the time, d	euse(s) end me ate end place,	enner es steted. and due to the d	euse(s)
	To the	To the com	29b. Signeture end title of certifier			1	29c. Licen	se number	2	9d. Date signe	d (Month, Dey,	Year)

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29b. Signeture end title of certifier

Twiceae How MM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

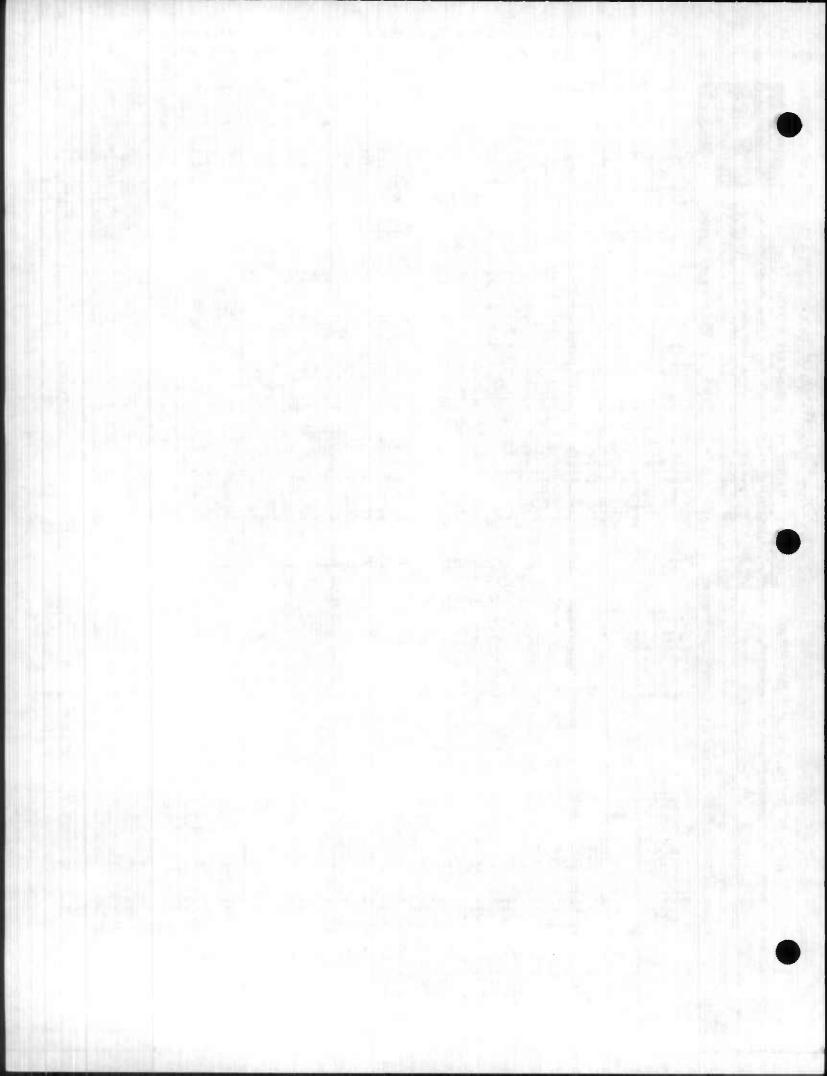
Out Chih Hou, M.O. A. 203 W. Main St. Cikton, M.O. 2/92 (
31. Date filed (Mogth, pey, Year)

DEC 2 2000

32. Registrer's Signature

Sports 31. Date filed (Mogth, Dey, Year)
DEC 2 2 2000

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Vear Ruth Loretta Moore December 19, 2000 2130 P 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Care Center Elkton Ceci: If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1□M 20 F 70 Yrs. NOV. 21, 1930 222-44-1988 Maryland Usual Residence of Decedeni 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 148 Maloney Road United States 21921 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Not Applicable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Charles Moore Cora J. Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty M. Lewis/Sister 148 Maloney Road, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/23/00 Cecilton, Maryland 22. Name end Address of Facility 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) 5 des neumece Due to (or as a consequence of): Schijo phoce Due to (or as a consequence of): Thubua, to penai Due to (or as a consequence of): Mentel Referdation 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 2UNo 1 Yes 1 Yas 2 No

Physician /Medical MPT Examiner

Box 68760.

P.0.

Records,

of Vital Physicien:

Division Attending death.

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After

s efter death

filled In

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Hospital

The law requires that the deeth certificate be

Physician

/Medical

Examiner

Funeral

Director

"natural", or itams 23s or 28s-f show

Director

Funeral

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Completed

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the Maryland

death

72 hours after

Pages 1 and 2 should be filed within 72 honent of Health and Mental Hyglene.
Int: If Item 27 is marked other than "naturary or other traumatic event, the Medical.

permit. Page Department of Important: if any injury or page.

21215-0020

Baitimore, Maryland

Examine Physician/Medical þ Completed

physician and the burial-transit 80 087 5.0 bloode page 2 80 Certification: To funeral 6

24 hours To the Hosp within 24 hos To the Fune completely fi edical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 1 Dinatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one)

Jui chie How HD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D04823

29d. Date signed (Month, Day, Year)

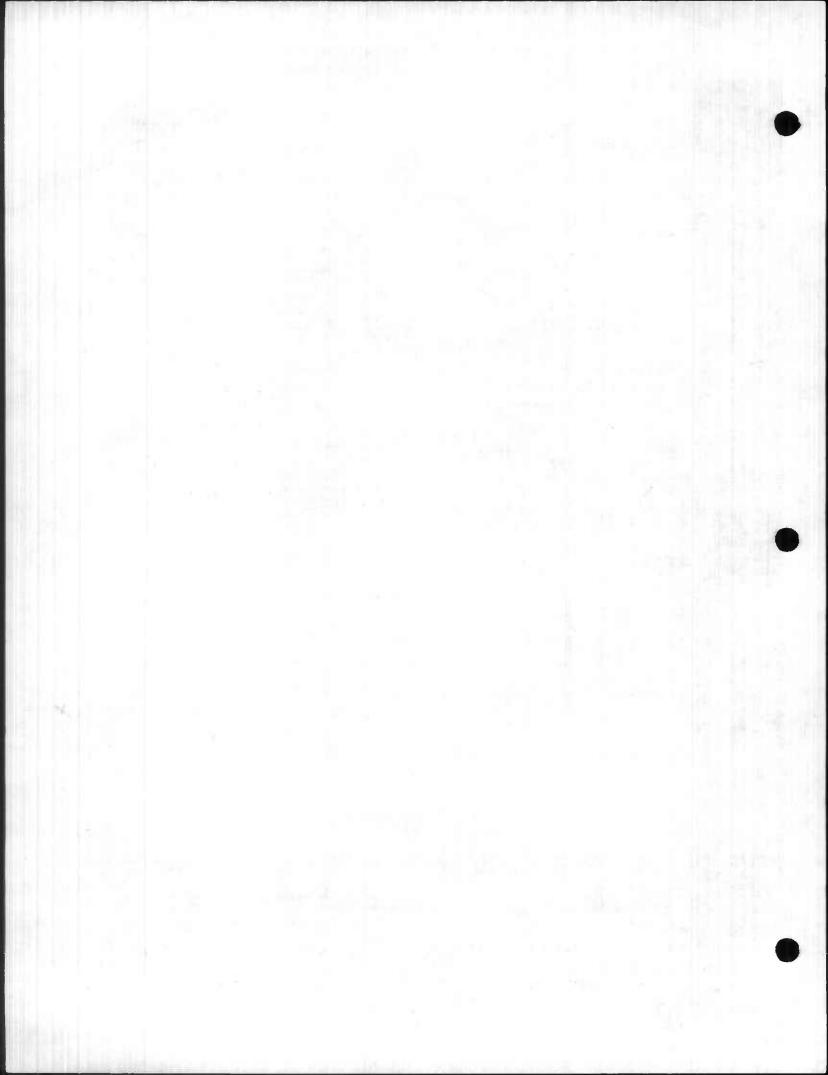
Elkton Md 21921 HSU MD 223 West man CHH JUI

29c. License number

31. Date filed (Month, Day, Year) State DEC 22 2000 Registrar

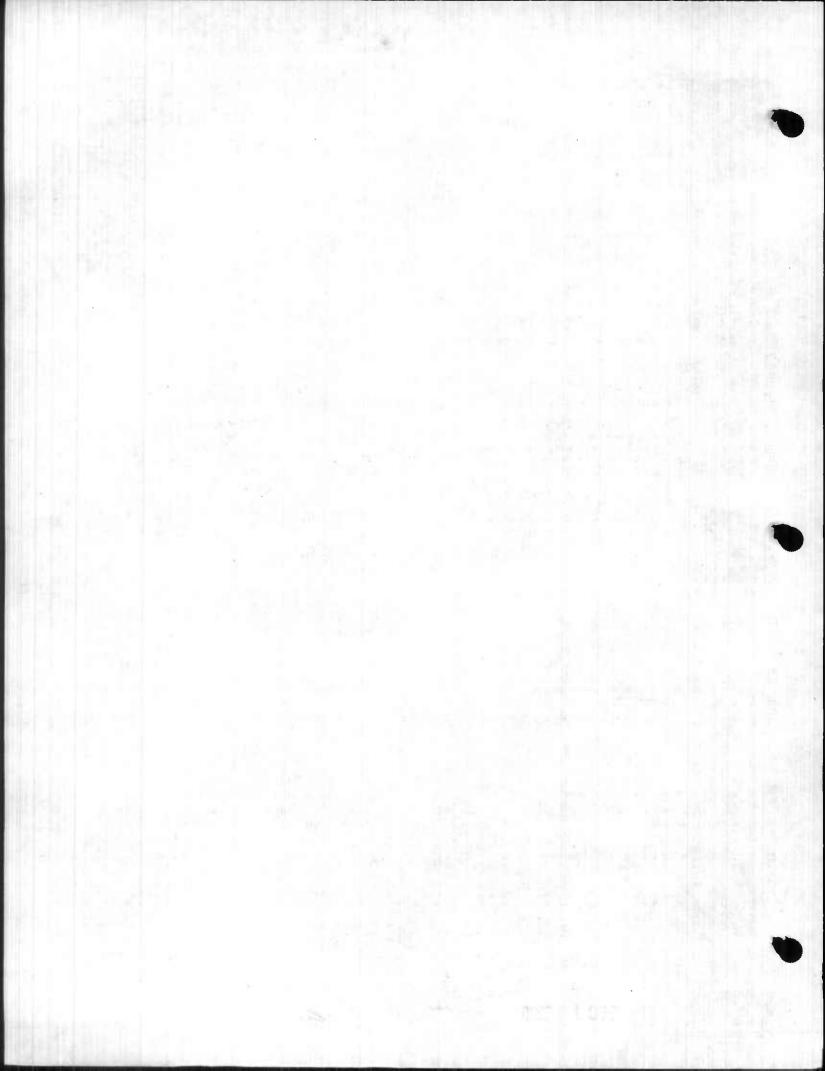
29b. Signature and title of certifier

32. Registrar's Signatura



						i waryian		rtificate of	Health and M Death		Reg. No.	J (4	24/3	
	Physicia /Medic			H MILT	ON MILL		₹.			2. Data of De Month Decemb	er 15,	Year 2000	3. Time of Death 5:20 PM	
	Examin Funeral Director	er	4039 Rin 5. Social Security No. 212-24-60	nehart I		7. Aga (In yrs.		If Under 1 Yaar Months Days			rth C	arrol 9. Birth Cou	place (State or Foreign ntry)	
	pu *		Usual Rasidence of 10a. Stata			10c Cit	y, Town or L	ocation					10d. Insida City Limits	
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	with the Maryland a or 28a-f show	Directo	10e. Street and Num		OII	10f. Zip Coda					10g. Citizen of	What Cou		
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		3e C	17. Fathar's Nama (First, Middle, La	ist)	Pa 5 6 1	Ţ	2000202	18. Mothar's Nama (First, Middle, Maiden Sumeme)					
laryla		To	17. Fathar's Nama (First, Middle, Last) Milton Wesley Miller 19a. Informant's Name/Ralationship (Type, Print) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Mary Ellen Stonesifer 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)										p Code)	
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Baltimore,	permit. Pages 'Department of Fimportant: If Ita		4 Donation	☐ Cramation 3 5 ☐ Othar (Spe		Stata	ematary, cra kler's		urch Cemei	2/18/00 tery	20c. Location Westm			
Bal	permit. Pa Departmen Important: any injury pnce.		Sue	1. Signature of Funeral Sarvice Licensee, 22. Nema end Addrass of Facility 91 Willis Street Westminster, MD 21157 3a. Part 1. Enter the disease, or complications that caused the death of not anter the mode of dying, such as cardiac or respiratory errast, Interval Batween Interval Batween										
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Division of	aling Phys h. After this funeral di	ation: To	1 Yas 221 27. Manner et Death 1 Natural 2 Accident	5 Panding Invastiga	28e. Data (Mon.	•	28b. Time of Injury	of 28c. Inju			idence 6 00 how injury occu		ify)	
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•	To the vithin To the comple	29d. Signature and title of certifiers 29d. Date signed (Month, 29d. Date signed (Month, 27/6/70							, vay, Year)					
			90. Name and address	Uggowit	zer M.D.	4500	Black		. Hampste	ead, MD	21074			
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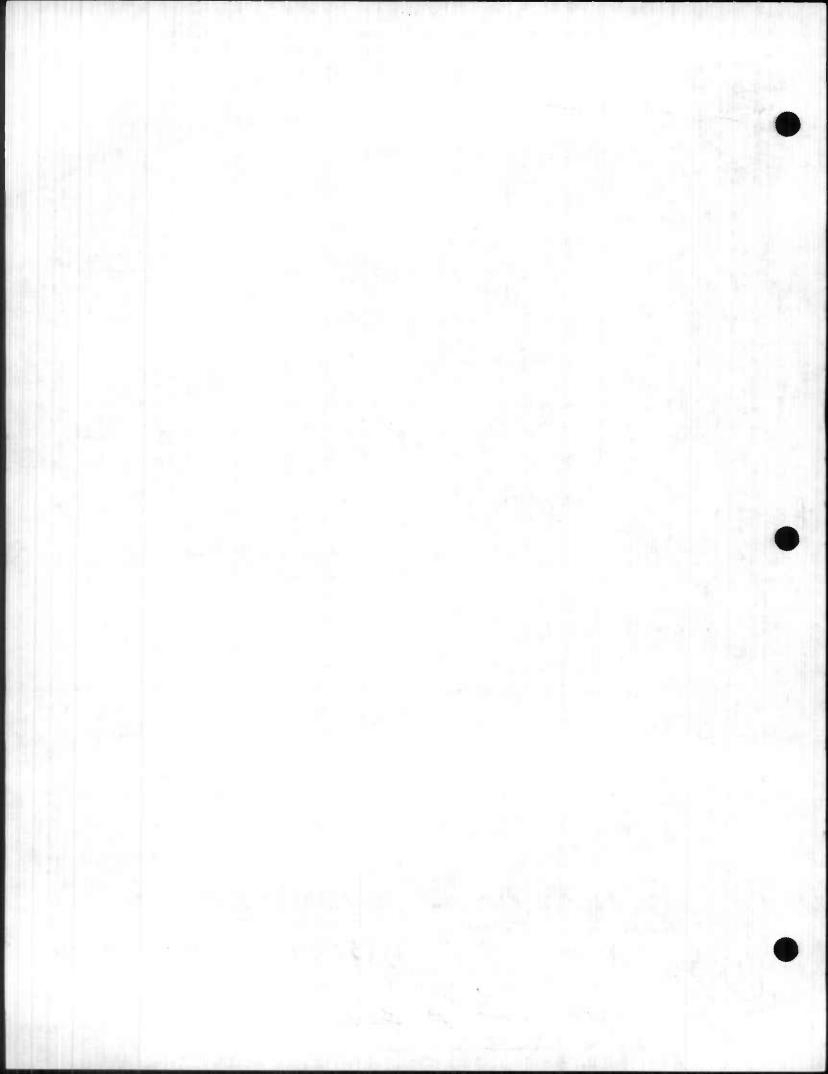


State of Mary

land / Department of Health and Me	ntal Hygiene	nn	1.21.71
Certificate of Death	Reg. No.		76414

			Certific	cate of	Death		Reg. I	No.	0	7641	
11.	1. Decedent's Name (First, Middle, L	ast)	BUEN			2. Dete d		Day	Yeer	3. Time of Deal	
Physician /Medical	Rosa Hercili					Decem	ber 1	17, 20		8:55 AM	
Examiner	4e Fecility Name (If not institution, g					wn, or Location of I		4c. County			
	Washington Adver		1 41	and the second		a Park		lontgo			
Funeral Director	626-84-4247	Sex 1	Mor	nder 1 Year hths Days	If Under : Hours		, Day, Yea	1949	9. Birthp Coun Guat	emala	
pu a	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location						1	0d. Inside City Lin	
lanyte aho	D :									toxyes 2□	
the N	MD Prince G	eorges nya	ttsville	f. Zip Code			100.0	Citizen of What Country?			
offer death with the Ma in flows 23s or 28s-1s from mult be need a Funeral Director	800 Rittenhouse	C+	10				109.				
eral	11. Marital Status	12. Was Decedent Ever in U	S 13 Was F	20783 Was Decedent of Hispanic Origin? (Specify Yes or if Yes, specify Cuben, Mexican, Puerto Rican, etc.)			r No-	Guatemala 14. Race - American Indian,			
by	1 Never Merried 22 Married	Armed Forces? 1 ☐ Yes ②☐No If Yes, Give Year or Dales:	111111111111111111111111111111111111111	specify Cub	Specify:	, Puèrto Rican, etc Guatemali	Black, White, etc.				
natural natura natural natural natura natura natura natura natura natura natur	15. Decedent's I	Education	16a. Decedent's	ecedent's Usual Occupation					siness/Inc		
- 4 -	(Specify only highest g	College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)								
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2 should be filed within and Mental thygiene. a marked other than surratic event, the Manatic event, the Ma	Nicolas Monroy				Jose	fina Fra	nco				
2 sho and la ma	19a. Informent's Name/Relationship	(Type, Print)	19b. Mailing Ad	dress (Street	and Numbe	er or Rural Route N	umber, Cit	y or Town,	State, Zip	Code)	
1 and 2 Health em 27 I	Alvaro S. Cruz/H	usband	800 Ritt	enhous	se St.	Hyatts					
- oth	20a. Method of Disposition		Pleca of Disposition cametery, cremetory	(Neme of or other pla	ce)	Date	20c.	Location -	City or To	wn, State	
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pernit. Peges 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 Ia marked other than eny Injury or other treumatic event, the Moss. To Be Comp	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC										
	23a Fart Enler the disease, or console, or heart failure. List onl	nalications that caused the deat						igton	DC Z	Approximate	
certificate be executed nding physicien and use as the burial-trensit nVMedical Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. — Due to (or as a consequence of): Due to (or as a consequence of):										
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definer: The lay certificate hes rector, page 2	THE STATE OF STATE OF						1 🗆 Yes	2 (1)No	1	☐Yes 2☐ No	
entificat sctor, p	25. Was case referred to medical				26 Plece	of Death (Check					
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tal or Attending P is after death. al Director: After t led in by the funer Certification:	3 Suicide 6 Could not determine	1 286. Piece of injury - At n				28f. Location (Street end Number or Rural Route Number, City or Town, State)					
To the Hospital or Attending Phymitin 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) end menner (Check only one) 1 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(s) end menner of the ceuse(s) and										
o the complete of the complete	29b. Signature and title of pertifier 29c. License number 25					29d.	Dale signed	d (Month,	Day, Year)		
- 5 - 0	Vaina	/	Do	053	719		DE	TEMPE	RI	7,2000	
(1)	30. Name and eddress of person who		n 23a) (Tuna Brins)		101		ya	.0.100	1 17	1,2000	
(')	RAJ. CHAWLA	3060 Mitc	hell ville	rd	Bowin	e mo	20	716			
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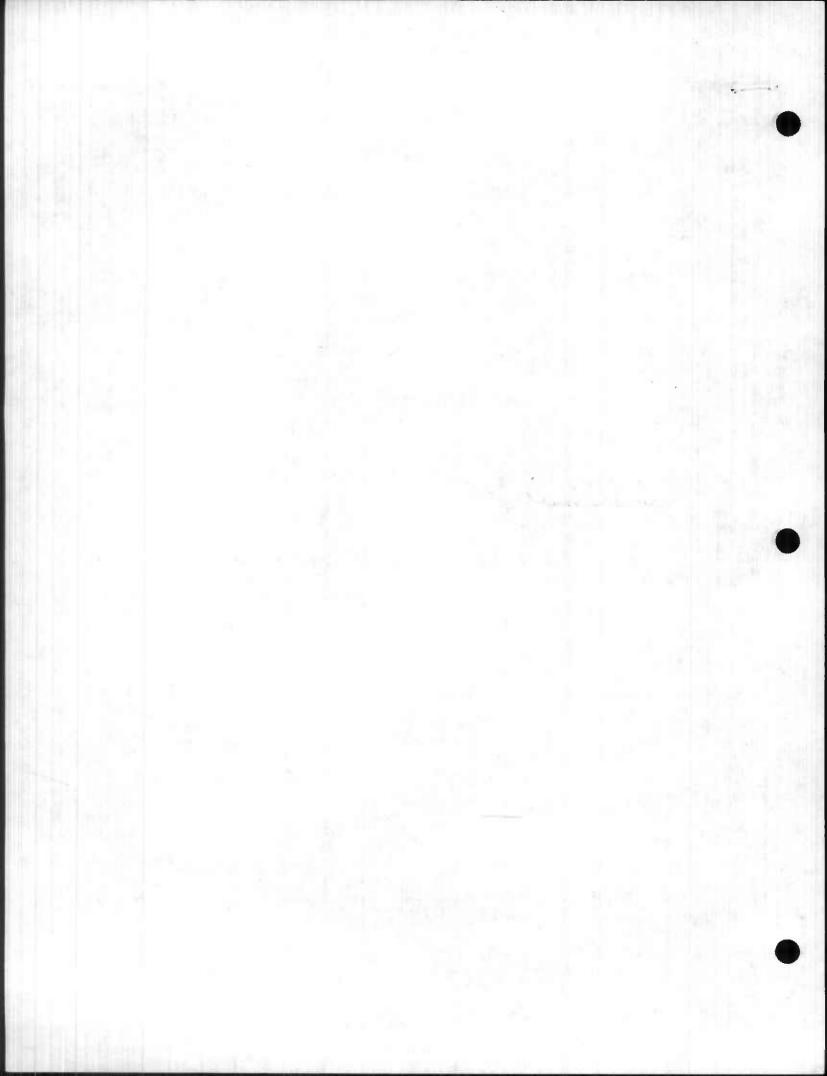


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend# 26.Per Phys.PGC 12-21-2000 2. Dete of Deeth 1. Decedent's Nema (First, Middle, Last) 3. Time of Deeth **Physician** 12/16/2000 McKENZIE 6:00 AM **JAMES** /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner STLVER SPRING MONT FOX CHASE REHAB If Undar 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5/2/13 5 Social Security Number 9. Birthplace (Stete or Foreign 7. Age (In yrs. lest birthdey) **Funeral** Months 1☐M 2□F Deys Hours WASHINGTON, DC 87 Yrs. 577-28-0724 Director Usual Residence of Decedent 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 28s-f show Yes 2 No Director DC N/A WASHINGTON 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 'natural', or flams 23a or Examiner must be 20019 USA #6 5629 CLAY PLACE NE Funeral 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Detes: 14. Race - American Indian, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) AFRO-AMERICAN 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas No Specify: Specify: þ 3 Widowed 4 □ Divorced r than 'natura the Medical E Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within ementary/Secondery (0-12) NONE (1-4or 5+) MATNTENANCE 12 YEARS MAINTENANCE WORKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fethar's Neme (First, Middle, Last) Mental P RUTH DUCKETT is marked WALTER MCKENZIE Aft. Pages 1 and 2 aho.
Department of Health and Me
Important: If them 27 is per any Injury or other
office. 19e. Informant's Name/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1924 SAVANNAH PLACE SE, DC 20019 SCOTT MCKENZIE (SON) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Buriel 2 Crametion 3 ☐ Removal from Stete CHESAPEAKE CREMATORY INC. 12/21/00 BELTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee • #CC0027 22. Name end Address of Facility JOHN T. RHINES CO., INCE 3030 12TH ST NE, DC 20017 First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediete Ceuse (Finel disaesa or condition resulting In deeth) Examiner Due to (or es e consequence of) Physician/Medical Examiner signed by the attanding physician and a be datached for usa as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated evants resulting in death) Lest Due to (or es e consequence of): Box 68760, Due to (or es e consequence of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 Nb 6 Probably 4 Unknown Records, p 24a. Wes en autopsy performed? 24b. Were eutopsy findings aveilebla prior to Completed completion of ceuse of death? page 2 certificate has 1 Yas 2 No Division of Vital Physician: funaral director, 25. Wes cese referred to medical axaminar? Be 26. Plece of Death (Check only one) Hospitel: Theatient To Other: 4) Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yas 2 No 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Dey Year) 27. Menner of the 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? spital or Attending Prous after death. 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 ☐ Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours a To the Funeral E completaly filled 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steled. 29e. Certifier edical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier D50678 500 30. Name end address of person who completed ceusa of deeth (Item 23a) (Type, Print) DIR WOOD 31. Dete filed (Month, I

DHMH 16 Rev 6/95

State Registra

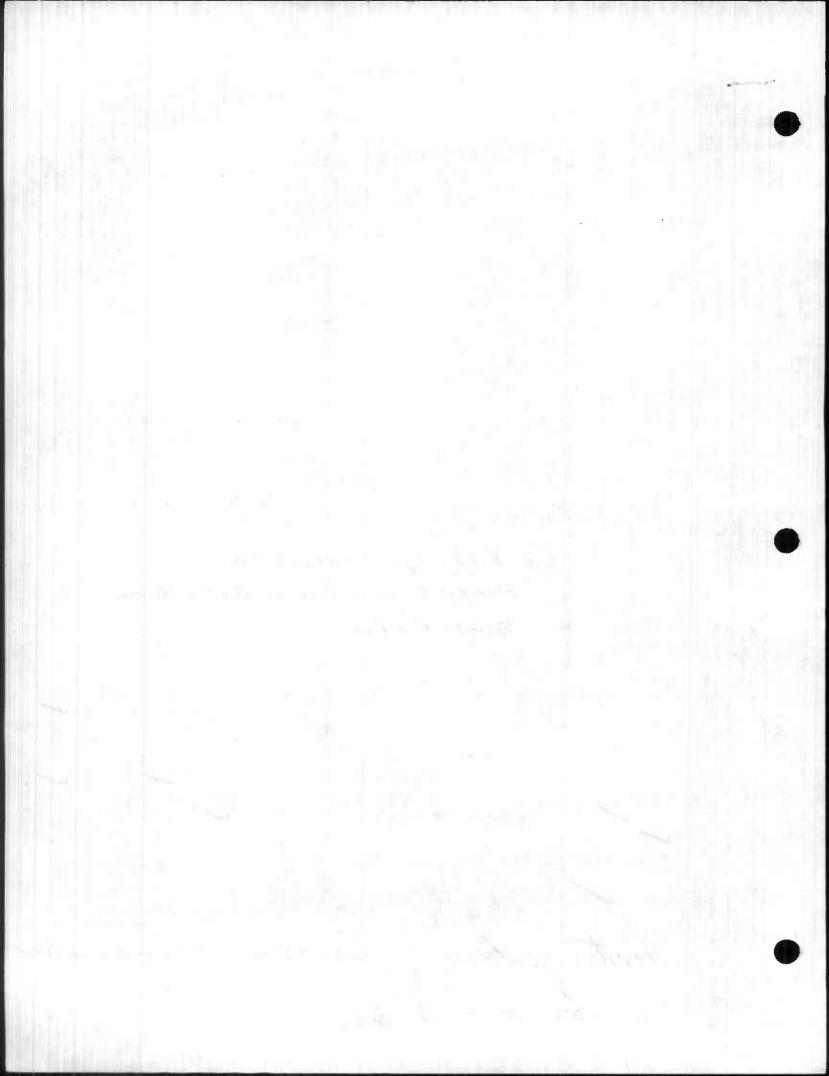
#2. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 42476

				Cer	tificate o	f Death		Reg	. No.		
	y are markety	1. Decedent's Name (First, Middle, Las	st)				2	2. Date of Death Month	Day Y	ear	3. Time of Death
	Physician /Medical	Kent Mitch	nell]	December		2000	8:27PM
	Examiner	4a Facility Name (If not institution, give						ation of Death	4c. County of	Death	
		2307 Cannonba	ll Court			1		ngton			eorge's
	Funeral Director	5. Social Security Number 6. S 579-62-4650	7. Age (In yrs. la	rst birthday) Yrs.	If Under 1 Ye Months Day		Min. Se	Date of Birth (Month, Dey, Yept. 19,	^(ear) 1947	Birthpla Count Wasl	ace (Stete or Foreign ry) D.C.
	2	Usual Residence of Decedent	40- 00-	T						140	ad In side Obert Imite
	ahov Set	10a. State 10b. County		, Town or Loc						10	d. Inside City Limits 1 Yes 2 No
	Serie Marie	Maryland Prince	George's		1-	Washin	gton	A			
	th with the Mer 23a or 28a-f a at be mother	10e. Street and Number 2307 Cannonbal	1 Court		10f. Zip Cod	2074	10g. Citizen of V 44 Unite			hat Country?	
21215-0020	do within 72 hours effer death with the Meryland organies than "natural", or items 23s or 28s-f show it, the Meryland and the most be notified at Completed by Funeral Director	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify C □ Yas 2□X			ify Yas or No- cen, etc.)	14. Race - Amarican India Black, Whita, atc. Specity: Blact		itc.
2-0		15. Decedent's Ed (Specify only highest gre	lucetion	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)				16	b. Kind of Busin	ness/ind	ustry
21		Elementary/Secondary (0-12)	College (1-4or 5+)	life. D			I OF WORKING				
	Hygiena. Hygiena. Hygiena. Hyser than	12th		Tailor					Self-	-	loyed
pu	走工者 5 m	17. Father's Name (First, Middle, Last)			18. Mother's Nama (First, Middle, Meiden Surneme) Mary Pauline White						
yla	should be and Mentel marked o	Earl Evans Mitchell						ry Pauli	ne Whit	.e	
Maryland	nd 2 aith a 27 is r trac	19a. Informant's Name/Relationship (<i>Route Number, (</i> t. Washi			Code) 20744
altimore,	agas ant of t: If h	20a. Method of Disposition 1 ABunal 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	metery, crem	sition (Nema of eatory or other) Memori	olece)	k 12,	Date 20 /22/2000	c. Location - Ci	1	
Balti	permit. Pa Departmen Important: any injury.	21. Signature of Funeral Service Licen		22.	Name and Ad		Ste	ewart Fu N.E. Wa			20019
/		23a. Part Entar tha disease, or com- shock or heart failura. List only	ourations that caused the death	Do not ente						0.	Approximate
x 68760,	deeth certificate be executed e ettanding physician and of for usa es the bunal-transit sician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Dondro	as a consequ	uence of):		EM	n, cy sy	nelso h	P	
Box	eth ce ettandii for usa clan/i		0.							1	
0.		Part II. Other eignificant conditions of	ontributing to death but not result	lting in tha un	darlying causa	givan in Part	1.	23b. Dld tob	acco use contr	ibute to	the cause of death?
۵	5 00 >						LĽ:	1 🗆 Yee	2□ No 3	Prob	ably 4 Hinknown
Records,	aw requir							24a. Was an performe		ava	ore autopsy findings nilable prior to npletion of ceuse death?
	age age							1 ☐ Yes	20 No	10	Yes 2010
Vital	cartifical rector, p	25. Was case referred to medicel			111-1-1	26. Plece	e of Death	(Check only one)			
	Physician: this carlificant director, TO Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien	t 3□ DOA	Other: 4 No	ursing Home	e 5 Desiden	ce 6 Other	(Specify)
on of	Attending Ph order: After thi by the funeral	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	(Month, Dey Year)	28b. Time of Injury		njury at Vork?		d. Describe how	injury occurred	1	
Division	* # # E C 12	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, stre	et, factory, offi	ce	26	8f. Location (Stre City or Town,	et end Number Stete)	or Aura	l Route Number,
	To the Hospital of within 24 hours at To the Funeral Dicompletely filled is Medical Cel		yelcian: To the best of my know niner: On the basis of examination and manner stated.								
	within To the comp	29b. Signature and title of certifier	,		29c. Lic	ense number			d. Data signed (
	2	1 (frantly)	no who		0	504	54	2	elem	Res	20,2000
	(5)	30. Name and address of person who	empleted cause of death (Item	23a) (Type I		, - , ,	/				
	9	Arastoo Yazday	i 11418 Livi	ingsto		Ft. Wa	shing	ton, MD	20744	+	
	. State Registrar	DEC 2 1 2000	32 Registrar's Signatu	A.	lon v	,					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Physician DENNIS CLIFFORD MOORHEAD 10:45 AM December 17, 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8500 Mike Shapiro Dr. #123 Clinton, MD Prince George's If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 24 Hrs. 6 Sex 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 1XM 20F Months Hours Min. 578-56-0078 57 Director January 30, 1943 Washington, D.C. Usual Rasidance of Decedent 10c. City, Town or Location 10a Stata 10b County 10d. Insida City Limits d other than "natural", or items 23s or 28e-f show event, the Medical Examiner must be notified at Prince George's Clinton 1 X Yas 2 □ No Directo 2 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8500 Mike Shapiro Drive 20735 #123 USA Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. Battimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after of government of Health and Mentall Hyptises.

Important: If teen 27 is marked other than "natural", or ites any injury or other traumatic event, the Medical Examines ands. hours after 1 Nevar Married 2 Married 1 Yas 2 No Specify ğ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Not employed None 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Clifford C. Moorhead Virginia J. Thornton 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Thornton C. Moorhead/Brother 1607 Camden Circle SW, Olympia, WA 98512 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cametion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 12/20/00 Alexandria, VA 22. Nama and Addrass of Facility CEDAR HILL FUNERAL HOME, INC. 21. Signature of Funaral Sarvice Licansee Cheatha 4111 Pennsylvania Avenue, Suitland, MD 20746 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, y one ceuse on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting In daath) ARTERIOSCLEROTIC HEART DISEASE Examiner Due to (or as a consequence ol): Examiner HYPERTENSION physician and the burial-trensit that the death certificate be axecuted Sequentially fist conditions, if any, leading to immadiata cause. Enter Undarfying Cause (Disease or Injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): DIABETES with L Leg Amputation Physician/Medical Dua to (or as a consequanca of): 88 for use as MORBID OBESITY ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. aigned by t 1 Yes 2 No 3 Probably 4 Unknown by lew requires 24b. Wara autopsy findings available prior to should should 24a. Was an autopsy performed? Completed complation of causa of death? page 2 s The 1 ☐ Yas 2 No certificate Physician: director 25. Was casa raferred to medical Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4□ Nursing Homa 5 \$\overline{D}\$ Rasidence 6 □ Othar (Specify) P 1 Yas 2X No After this control funerel dir 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be determined

Records, P.O. Box 68760, Division of Vital or Attending deeth. Director: / after 24 hours

To the F within 2. To the F

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year)

29b. Signatura and titla of certifian

vario

3 Suicide

29a. Cartifier (Check only one)

4 Homicida

30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura parks

28a. Placa of Injury - At home, ferm, street, factory, office building, atc. (Specify)

ORIGINAL

Rosario Fernandez 7700 Old Branch Ave., Clinton, MD 20735

15 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data end place, and due to tha causa(s) and mennar es stated.

26 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

D19518

29c. Licansa number

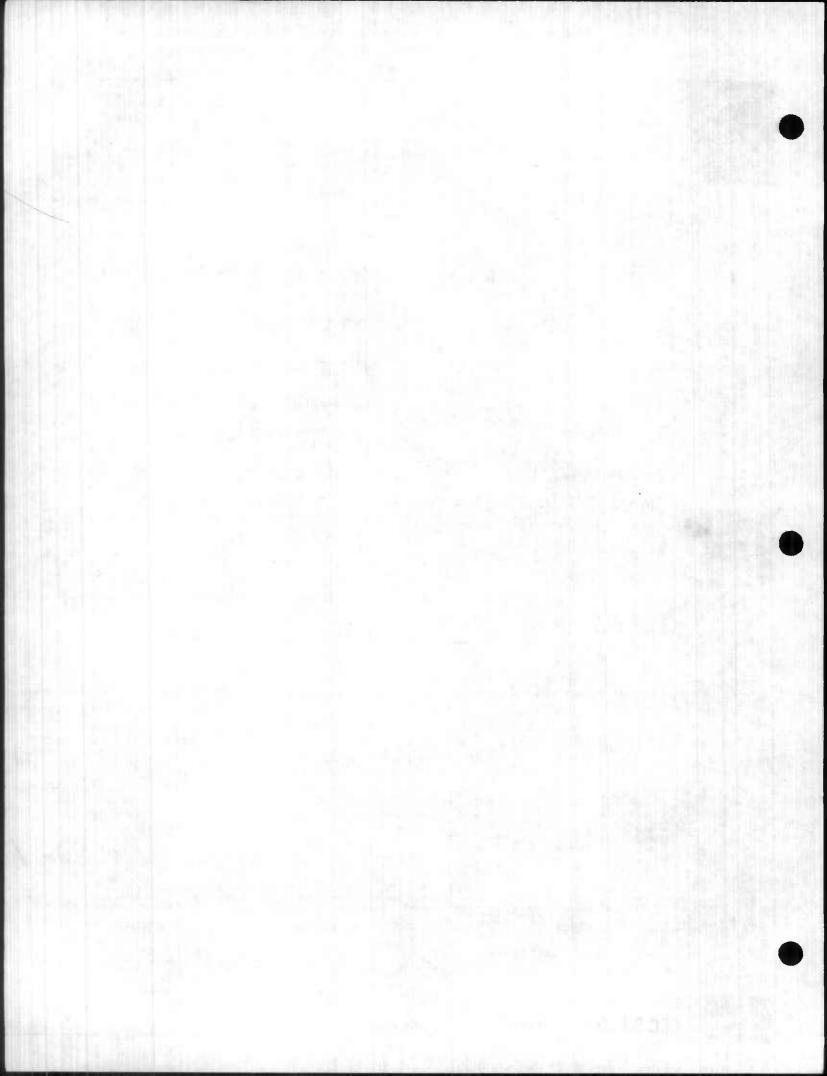
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

12/19/00

29d. Data signed (Month, Day, Year)

State Registrar

edicai



State of Maryland / Department of Health and Mental Hygiene Cartificate of Death

42478

. Decedent's Name (First, Midd	dle, Last)							2. Date of De			Vaar	3. Time of D
Robert Erne	st Marti	ini. Sr.						Month	Dey		Year	7:00
a Facility Name (If not institution					4	4b. City, To	wn, or L	ocation of Deat			of Death	1 00
Doctor's Comm	6. Sex	7. Age (In yrs.	last highday	If Under	1 Yeer	Lan		6 Date of Bir				orge's
	1.XM 2□ F		Yrs.	Months	Days	Hours	Min.	6. Dete of Bir (Month, De				lece (Stete or a
195-20-6059		73	****					Oct. 2	6, 19	2/	Penr	nsylvan
Jsual Residence of Decedent 0a. State 10b. Count	v	10c Cit	y, Town or Loc	eation			-			-	110	0d. Inside City
												1 X Yes 2
Maryland Prin	ce George	s's N	lew Car									
0e. Street and Number				10f. Zip	Code				10g. Citize	en of W	hat Coun	itry?
8318 Quentin	Street				2078	4			U.S	.A.		
1. Maritel Stetus	12. Was De	ecedent Ever in U, Forces?	.S. 13. V	Vas Deced	dent of H	lispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	0- 14		- America	an Indian,
1 Never Married 2 Mar		s 2 No			100	Specify:						0.00
3 ☐ Widowed 4 ☐ Divorce	d Year or	Dates: WWI			Z LA IVO	Specify.			3	specify:	Whi	ite
15. Deceder	nt's Education	dl	16a. Deced	ent's Usua	al Occup	ation	of work	ina	16b. Kind	d of Bus	siness/Ind	dustry
Elementery/Secondery (0-12)	est grade completed	(1-4or 5+)	life. E	O NOT us	se retired	during mos	UI WUIN	ang	PC	s. Pe	ennes	ylvania
Lioniary (o 12)	5+	(1.40.01)	Tea	cher								ol Syst
7. Father's Name (First, Middle	, Last)					18. Mothe	r's Nam	e (First, Middle				
Frank I.	Martini					Flo	rend	e Ine	z Sci	hult	t z	
19e. Informent's Name/Relation			19b. Mailin	a Address	(Street			ral Route Numb				Code)
Robert E. Mart		- Con						., Prir				
Oa. Method of Disposition	IIII, JI.	20b. P	lace of Dispos	ition (Nar	ne of		5 Ku	Dete				wn, State
1 ☐ Burial 2 X Cremation		m State	emetery, crem	etory or o	ther plac		- 1					
4 □ Donation 5 □ Other (5	- 4	Met	and the same of th					2/22/00	Alex	kand	lria,	Virgi
21. Signature of Puneral Service	Licens66	/	1 1 1			ss of Facilit						
1//	1/11	1						ne, P.A		*11.	o MT	2078
23a. Part1. Enter the disease, o	or complications that	t caused the deat								TTT6	9 111	2010
shock, or heart failure. Lis		6- Al	n. Do not ente	er the mod	le of dyin	ng, such as	cardiac	or respiratory e	errest,			Approximate
	of only one cause on	n each line.	n. Do not ente	r the mod	le of dyin	ng, such as	cardiac	or respiratory e	errest,		-	Approximate Interval Betw Onset and Do
mm adiata Causa (Final	only one cause on	n each line.									 	Approximate Interval Betw Onset and D
mmediate Cause (Final disease or condition	a.	n each line.								hoc	15	Approximate Interval Betw Onset and De
	a	each line.		14	vt			or respiratory e		hoc	-15	Approximate Interval Betw Onset and D
disease or condition	a	each line.	RE BR	14	vt					hoc	15	Approximate Interval Betwo Onset and De
disease or condition esulting in death)	a	Due to (c	RE BR	uence of):	VX					hoc	15.	Approximate Interval Betw Onset and Do
disease or condition esulting in death)	a	Due to (c	A B B A	uence of):	VX					hoc	15	Approximate Interval Betw Onset and Da
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Fun Dire

permit. Pages 1 end 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or itams 23e or 28e-f ahow

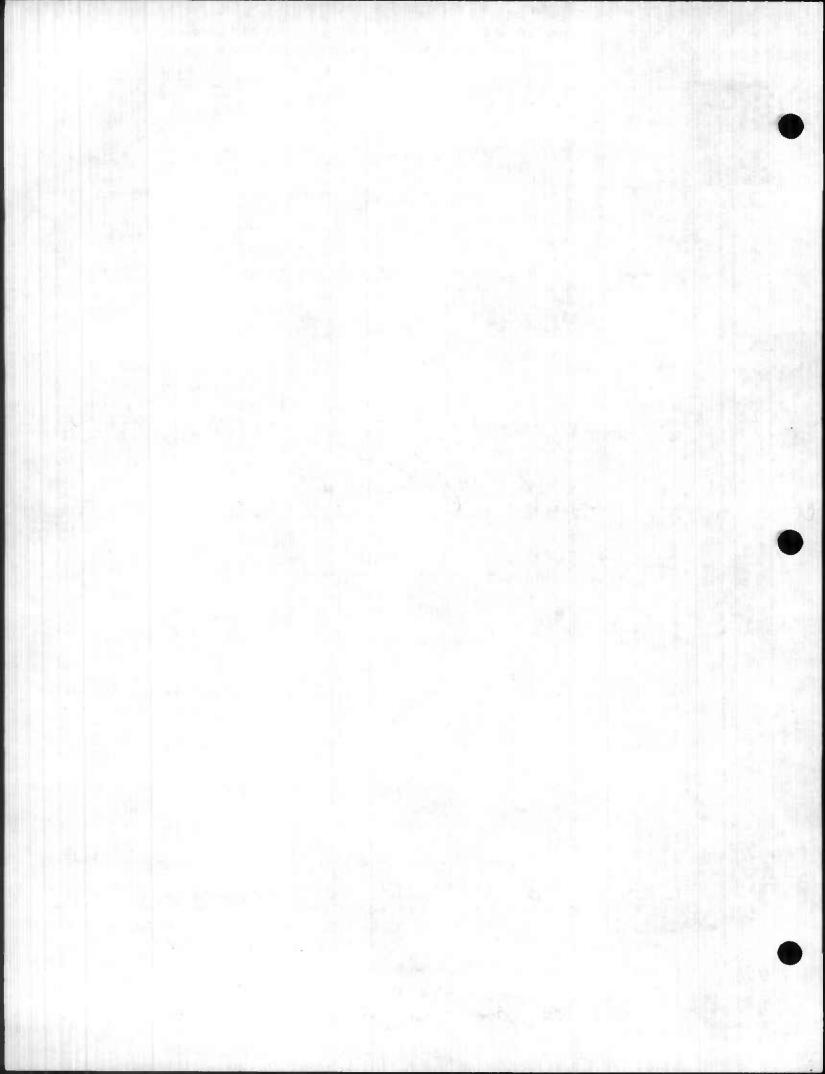
Physic /Med Exam

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician end

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

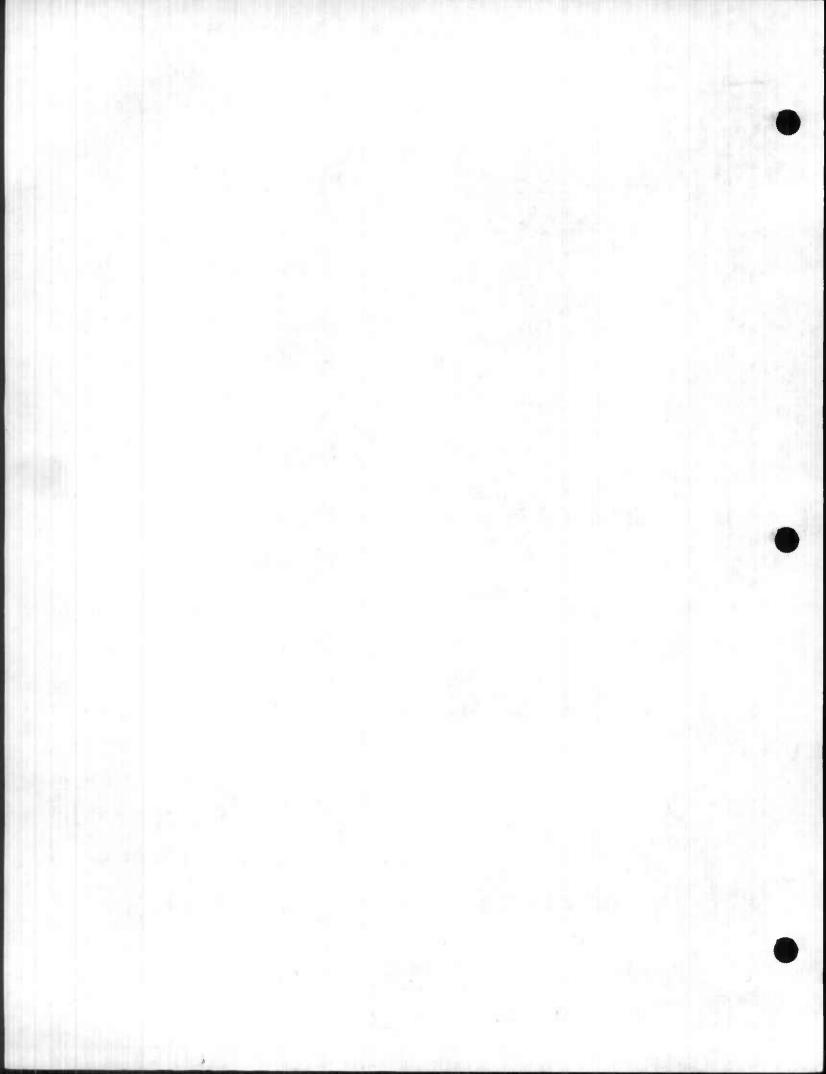


State of Maryland / Department of Health and Mental Hygiene

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		C	ertificate of	Death	Rec	. No.	
	1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month	Dey \	3. Time of Deeth			
Physician /Medical	Mari	a M. Mende:	z		Decembe	r 18,2	000 10:45 PM
/Medical Examiner	4a Facility Name (If not institution, give street end n	um <i>ber)</i>		4b. City, Town, or Lo	cation of Death	4c. County of	
	12304 Firtree Lane		0.00	Bowie			Georges
ral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthda 75 Yrs	Months Devs	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day,) NOV • 16	(eer)	Birthplace (State or Foreign Country)
tor	548-42-2694 ^{1□ M 2} ♥F	,1925	Mexico				
10.44	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
_							No Yes 2 No
octo	Md. Prince Georg	es Bow:			100	. Citizen of Wh	**
Funeral Director	10e. Street and Number 12304 Firtree Lane		10f. Zip Code 2071	5	103	USA	at Couring?
ner	11. Marital Status 12. Was De Armed	cedent Ever in U,S. 1	3. Was Decedent of h	Hispanic Origin? (Spe	cify Yes or No-		American Indien, White, etc.
by Fu	1 Never Merried 2 Married 1 Yes	1 ☐ Yes 2♥ No If Yes, Give 1♥ 1♥ Yes 2☐ No Yeer or Dates:					White
Completed	15. Decedent's Education (Specify only highest grade completed	f) (G	cedent's Usual Occupive kind of work done	during most of working	ng 16	Sb. Kind of Busi	ness/Industry
n jd	Elementery/Secondary (0-12) College	(1-4or 5+)	e. DO NOT use retire	nd)			
Co	12		Homema	aker 18. Mother's Name		Own ho	
event, the Be Con	17. Fether's Neme (First, Middle, Last)	es Mendoza					
To To			Reyes				
5	19a. Informent's Name/Relationship (Type, Print)		ailing Address (Street				
Per l	Margarita M. Rivas		304 Firt:	ree Lane		·	ZU/ID ity or Town, State
0 = 0	20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State cemetery, o	cremetory or other pla plitan Cr		-19-00		dria, VA.
ans injury	21. Signature of Funeral Service Licenses	- 11	22. Name and Addre	ess of Fecility	all Fur	oral	Homo
\$ 8	1411 130	call	6512 N.W				Md. 20715
11	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or	t caused the death. Do not					Approximete Interval Between
cian		1					Onset and Death
lical	Immediate Ceuse (Finel disease or condition	OCAMDIA	-LINF	ALCIT	00		TEN YEAR!
ner	resulting in death)	Due to (or as e con		1	0000	\sim	
Je J	(0)	LONARLY	MUR	HY ()	12, EAZ	7	
Examiner	Sequentially list conditions,	Due to (or as e con	sequence of):	,			
	if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury						
edical	thet initiated events resulting in death) Lest	Due to (or as e con	sequence of):				
· ×							
Sient Sient							
detached for use	Part II. Other significant conditions contributing to			iven in Pert I.			ribute to the cause of death?
page z snould be detached for us.	END SINGE IVE	NAL DIS	SME		1 Ye	2 No	3 Probably 4 Unknown
should be det					24e. Was en		24b. Were eutopsy findings evailable prior to
sho					perioriti		completion of cause of death?
Comp					1 ☐ Yes	200 No	1 ☐ Yes 2 ☐ No
ğ 0	25. Was case referred to medical			26. Place of Deatl			10100 2010
I director, par To Be Co	examiner?	☐ Inpatient 2☐ ER/Outpa	stient 30 DOA Ot	ther: 4 Nursing Ho	11	ice 6 Other	(Snacihi)
E 70		e of Injury 28b. Tim	e of 28c. Inju		28d. Describe hov		
funaral	1 Naturel 5 ☐ Pending (Me 2 Accident Investigation	onth, Dey Year) Inju		ork?]Yes 2 No			
ed in by the funara Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pla	ce of Injury - At home, farm	, street, factory, office		28f. Location (Stre	et end Numbe	r or Rurel Route Number,
er din	4 Homicide bui		City or Town,	Stere)			
completely filled in by the	29a. Certifier (Check only 2 Medical Examiner: On the	ne best of my knowledge, de basis of examination and/o	eath occurred et the ti	ime, date end plece, opinion, death occurr	end due to the cer ed at the time, dat	use(s) and men te and plece, er	ner es steted. nd due to the cause(s)
To the Funeral Director: After completely filled in by the funa Medical Certification	one) and ma	anner stated.					
00	29b. Signature engititle of certifier	MO	29c. Licen	se number	00	TEMR=	(Month, Day, Year)
		10(5)	0	7100 4	VL	VIII)	11,000
)	30. Name and address of person who completed ca	use of death (Item 23e) (Ty	pe, Print)	FHUES	TAKOM	APAR	(Month, Day, Year) FR 19, 2000 K, MD 20912
	SITEEU CIWIVICI -)	Bridge City	L 1 10 12 00 1	711100	7. 1. 0 17.1	,	/
State	31. Date filed (Month, Dey, Year) 32.	Registrer's Signature	2 × 2 × 1				

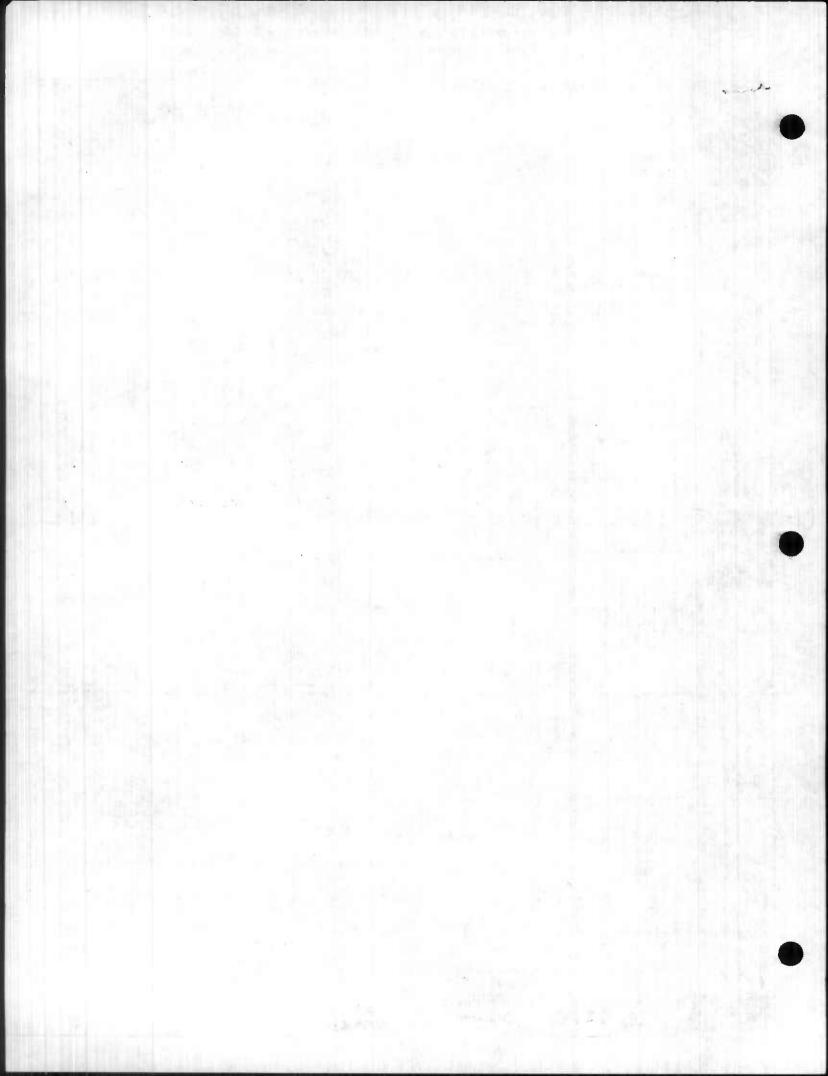
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State of Maryland / Department of Health and Mental Hygiene

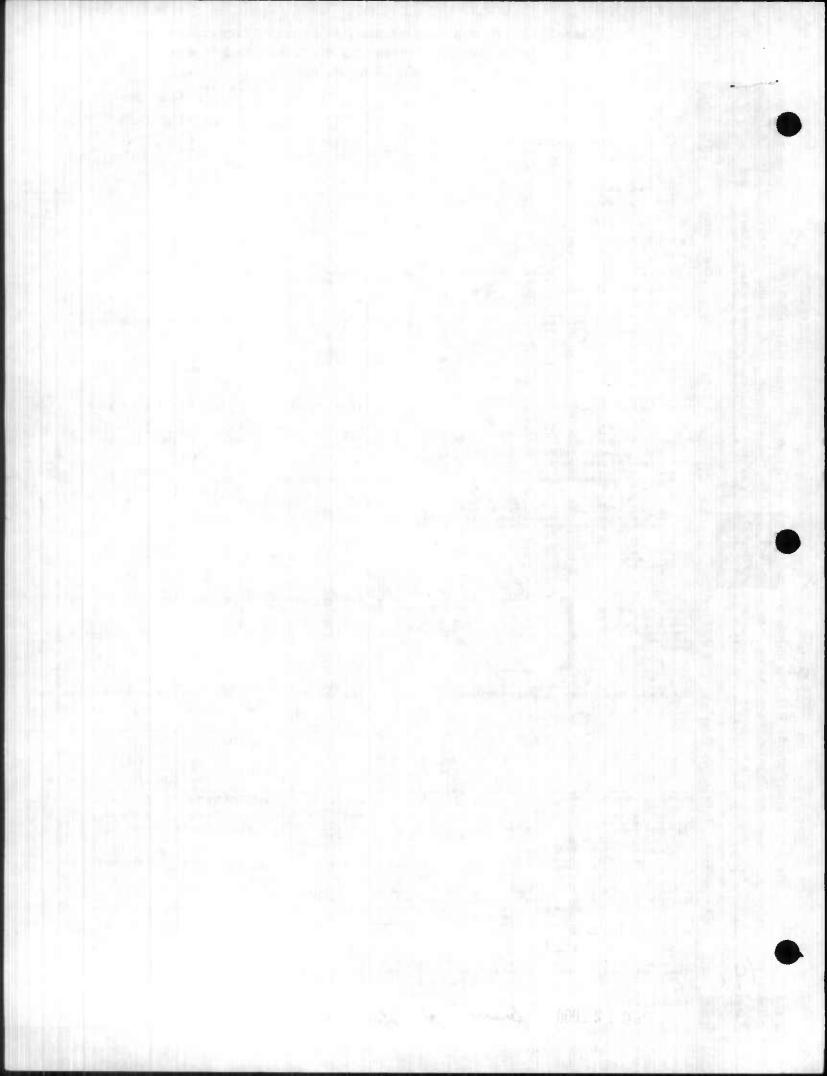
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	Certifi	cate of Death	Re	g. No.	
والمداحة الم	Decedent'a Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
Physician /Medical	Pauline Messineo		December	9:25pm	
Examiner	4a Facility Name (If not Institution, giva street and number)	4b. City, Town, o	r Location of Death	4c. County of De	
	6505 Springbrook Lane	Clinton		Prince G	enrees
Funeral	5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday)	Under 1 Yaar If Undar 24 Hr			inthplace (State or Foreign Country)
Director	228-05-1172 1 M 28 F 85 Yrs. MC	nths Days Hours Min	July 4,	1915 Vi	rginia
	Usual Residence of Decedent				
1 H	10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
filed roto	Maryland Prince George Clinton				to Yes 2 □ No
or 28s-fa be notified Director	10e. Street and Number	of. Zip Code	10	g. Citizen of What C	Country?
at a	6505 Springbrook Lane	20735	IIr	ited Star	tes America
iner mat Funeral	11. Marital Status 12. Was Decedent Evar in U.S. 13. Was	Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Ал	erican Indian,
3	1 Never Married 2 Married 1 Yas 2 Table		orto Hican, atc.)		
þ	3∕2 Widowed 4 □ Divorced If Yes, Give Year or Datas:	es ZEINo Specify:		Specify: W	nite
Completed	15. Decedent's Education 16a. Decedent's	Usual Occupation	10	6b. Kind of Busines	s/Industry
ple	(Specify only highest grade completed) (Give kind life. DO N	ot work done during most of w IOT use retired)	rorking		
E O	4 Housewii	Ee	C	owned Home	e
Bec	17. Fathar's Nama (First, Middla, Last)	18. Mother's N	ame (First, Middle, M.	aidan Sumama)	
0 8	Robert Lee Haley	Emma V	Weeks		
-				City or Town, State,	Zip Code)
	20a Method of Disposition 20b. Plece of Disposition	(Name of	1 1		
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		70/00/00		
				Brentwoo	od, Maryland
500	For	Lincoln Fune	ral Home		
	2 Nam & w UM = 340	l Bladensburg	Road, Bren	twood, Ma	
	23a. Part1. Enter the diseasa, or complications that caused tha death. Do not antar thi shock, or heart feilure. List only one ceuse on each line.	a moda of dying, such as cardi	ac or raspiratory arras	st,	Intervel Between
cian					Onset and Death
ical ner	Immediate Cause (Final disaase or condition CALCI NOMA OF	COLON			
	resulting in deeth) Due to (or as a consequence	e of):			1
burial-transit					1
Cam	Sequentially list conditions. Due to (or as a consequence	e of):			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olseese or injury				
edical	that Initiated events resulting in death) Lest Due to (or as a consequence	e of):			
2					1
	0.		-1 100 734		Î
	Part II. Other eignificant conditions contributing to death but not resulting in the under	ying ceuse given in Part I.	23b. Did tob	acco uae contribu	te to the cause of death?
Physic	HYPERTENSION		1 □ Ye	8 2 No 3	Probably 48 Unknown
20 20	THE POLICE OF THE PARTY OF THE				
8	DEMENTIA		24a. Was en	available prior to	
piet	201111111111		-		completion of ceusa of death?
Completed			1 □ Yas	s 211 No	1 Yes 2 No
	25. Was cese referred to medical	26 Place of D			22.10
o Be	examiner? Hospital:	Other			nacify)
1: To		LI DOA 4LI Nuising			recity)
tion	1 Natural 5 Panding (Month, Day Year) Injury				
Ca	2 Accident		July 4, 1915 Virginia July 4, 1915 Virginia		
arti	4 Homicide determined determined 28e. Place of Injury - At home, ferm, street, full building, etc. (Specify)	outor, j., oniou	City or Town,	State)	
edical Certification:	20a Capillar 19 Cada Thursday	suggested at the other state of the state of			as atota d
lica	(Check only 21 Mudical Examiner: On the basis of examination and/or investig	urred at the time, date and pla- jation, in my opinion, deeth oc	ce, and due to the cer curred et the time, da	use(s) and manner te end piece, and d	ue to the cause(a)
Me	one) and manner stated. 29b. Signature and title of out the	29c. License number	29	d. Date signed (Mo	nth. Dav. Year)
	Solution and metallic MD			12/10/	2000
)	1 1/1/1/			12/17/	2000
	30, Name and address of person who completed cause of death (Item 23a) (Type, Print		112-2 0.		11 7.72
	VENKAT. S. KAMANAN 7501 SURV	4775 (COAD	# 50+ 66	INTON "	N) 20 755
State	31. Date filed (Month, Day, Year) 32. Registrar's Signatura	Western .			
istrar	DEC 2 2 2000 Serve S.	ould			
lev 6/95	anini	MAI			
	ORIGI	NAL			



State of Maryland / Department of Health and Mental Hygiene 00 42481

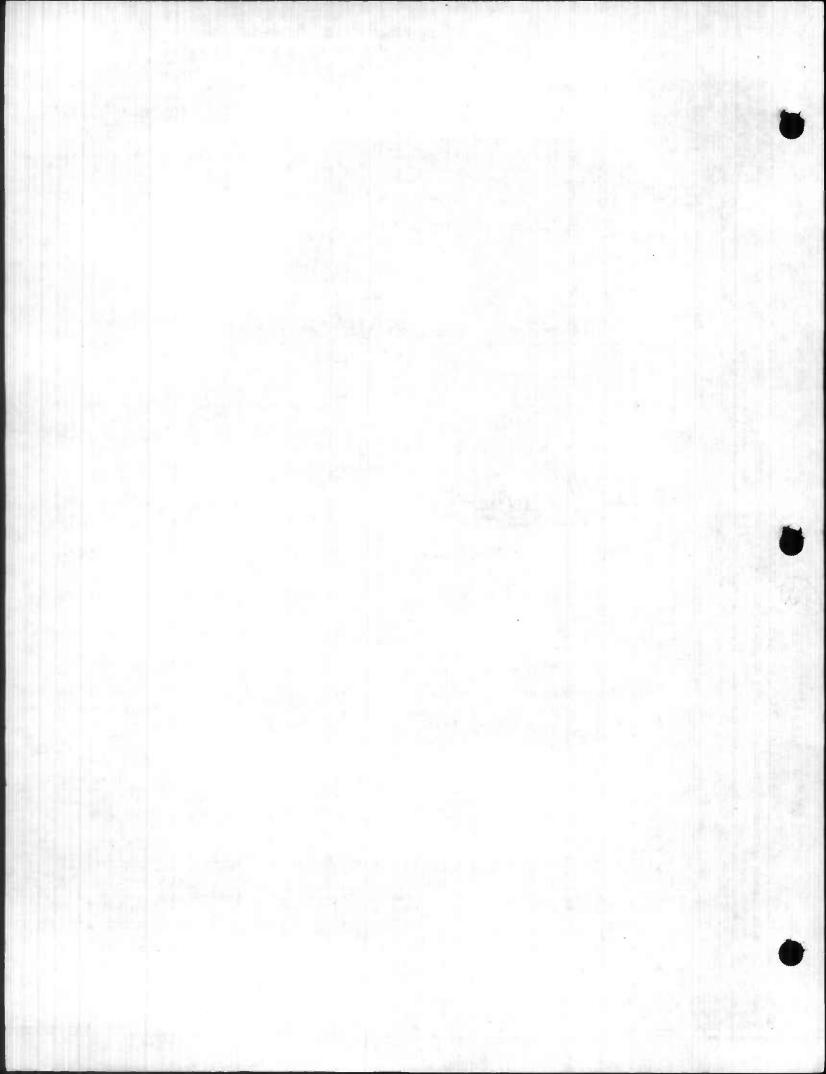
	Certificate of Death		Reg. No.				
sician	1. Decedent's Name (First, Middle, Last)	2. Date of De Month DECEMBE	2. Date of Death Month Day Year 3. Time of Dea				
edical	OMELIO RUFINO MARTINEZ			2000	11:05am		
miner	4a Facility Name (If not institution, give street end number) 4b. City, Town WASHINGTON ADVENTIST HOSPITAL TAKOMA	n, or Location of Deat PARK	MONTG(
eral tor	5. Social Security Number 212-68-3171 6. Sax 80 7. Age (In yrs. last birthday) 80 Yrs. 181 Days Hours		th Years 20	9. Birthpla Countr	ce (Stata or Foraig		
	Usual Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location			10	d. Insida City Limits		
٥	MARYLAND MONTGOMERY SILVER SPRING				YEVas 2 No		
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of V	What Countr	v?		
	1400 FENWICK AVENUE APT#901 20910		U.S.A.				
event, the Medical Exemples must be notified at Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever In U.S. Armed Forces? 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever In U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Specify Cuban, Mexican, I Yes, Give Year or Dates:	n? (Specify Yas or No Puerto Rican, etc.)	Blac	ee - America ck, White, a V'HISPA	tc.		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) MAILMAN	f working	16b. Kind of B		ustry		
		Name (First, Middle					
To Be	ENRIQUE MARTINEZ ROQUE CONCE	PCION RAMI	REZ				
 	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of	or Rurel Route Numb	er, City or Town,	State, Zip I	Code)		
	MADELEINE CHESTNUT/DAUGHTER 10480 HULL COURT WA	ALDORF, MAR	YLAND 20	0601			
	20a. Method of Disposition 20b. Place of Disposition (Neme of	Date	20c. Location -	City or Tov	vn, State		
	1 Surial 2 □ Cremation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify) MARYLAND NATIONAL PARK	12/9/00	LAUREL	, MARY	YLAND		
of for use es the burial-transit and property of the burial-transit and property of the burial transit and transit and transit and transit and transit and transit and transit and transit and transit and transit and transit and transit and transit and transit and transit and transit and transit a	23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as calculated assessed to condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	20 F 2V (PROST	AGE	Approximate interval Between Onset and Death		
Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use co Yes 2□ No		the cause of deat		
by PI	BONE WELL SUBSIN		1 108 2 HO	307100	ably 4L[Olikilo		
Completed t	BONE WELHZUHZIN		s an autopsy ormed?	ava	re autopsy findings ilable prior to apletion of cause leeth?		
Con		10	Yes 2 No	10	Yes 2□ No		
completely filled in by the funeral director, page Medical Certification: To Be Com	examinar?	t Deeth (Check only	one)				
	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nurs	ing Home 5 Res)		
	27. Manner of Dèath 1	0	28d. Describe how injury occurred				
Certifi	4 Homicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)		(Street end Numl own, Stete)	ser or Hurei	Houle Number,		
edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or inveatigation, in my opinion, death and manner stated.						
M	29b. Signatura and title of certifier 29c. Signatura and title of certifier 29c. Signatura and title of certifier)(29d. Date signe				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K, IV D HA KAT, AD 7610 CARROCC (AVG 623)	UTAK	om A D	ARK			
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	~	1220	112			
166	DEO 19 2000 Barrier &						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended State of Maryland / Department of Health and Mental Hygiene Line 28b./WCHD Certificate of Death 12-18-00/SC 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Dev **Physician** December 14 1840 Katharine Hughes Moran 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year Months Deys If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) 6 Sex Birthplaca (Stata or Foreign Country) **Funeral** 1□M 28 F 212-26-2871 86 Director July 17, 1914 West Virginia Usual Residence of Decedent the Mandand 10a Steta 10c. City. Town or Location 10d. Inside City Limits 10b. County r than "natural", or itema 23a or 28a-f ahow 1 ☐ Yes 2 ☑ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13141 Fountain Head Road 21742 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indien. Black, Whife, etc. 72 hours siter 1 Never Married 2 Married 1 Yas 2 No Specify: White p 3 Widowed 4 Divorced "natural", Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) homemaker home other 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fether's Name (First, Middle, Last) 12 should be f h and Mental H Timothy Joseph Hughes Mary Ann Mulry 19b. Meiling Address (Straet end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itsm 27 is m any injury or other traum 13141 Fountain Head Road Hagerstown, Maryland 21742 of Disposition (Nema of Deta 20c. Location - City or Town, Stete John A. Moran Husband Baltlmore, 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 12/19/00 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery 21. Signeture of Funerel Service Licenses Gerald N. Minnich 305 N. Potomac Street nmive Funeral Home Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician Immedieta Cause (Finel diseese or condition resulting in daeth) APPROTON /Medical Examiner Dua to (or es e consequence of): Physician/Medical Examine Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Diseesa or injury that initieted events resulting in death) Lest Due to (or es e consequence of): MORAN, KOTHARINE 2 23b. Did tobacco use contribute to the cause of death? Pert If. Other afgniffcant conditions contributing to death buf not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown b 24b. Were autopsy findings available prior to completion of causa of deeth? 24e. Wes en eutopsy performed? Completed page 2 this certificate has 1 Yes 2 No 1 Yes 2 No 25. Wes casa referred to medical 8 26. Placa of Daath (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No as 2 No Inpatiant 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending investigation FERL AT Komb 2-3-2000 unknown 1 Yes 2D Accident after death Director: 28e. Plece of Injury - At home, ferm, streat, factory, office building, atc. (Specify) 6 Could not be datermined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 4 | Homicide TOUNTAIN MOTORP PROSTON 8 Homb To the Hospital within 24 hours a To the Funeral C 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier edicai (Check only 29b. Signefure and title of codifier 29c. Licensa number 29d. Date signed (Month, Day, Year) @ Hombin 15, 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) WRNA 112 / ANIN -MP 19286 MESODOW VIEW DR KAGERSTMA MIS -mp Us Conin BRNOST 31. Dete filed (Month, Dey, Year) 32. Registrar's Signetura DEC 1 8 2000 Registrar

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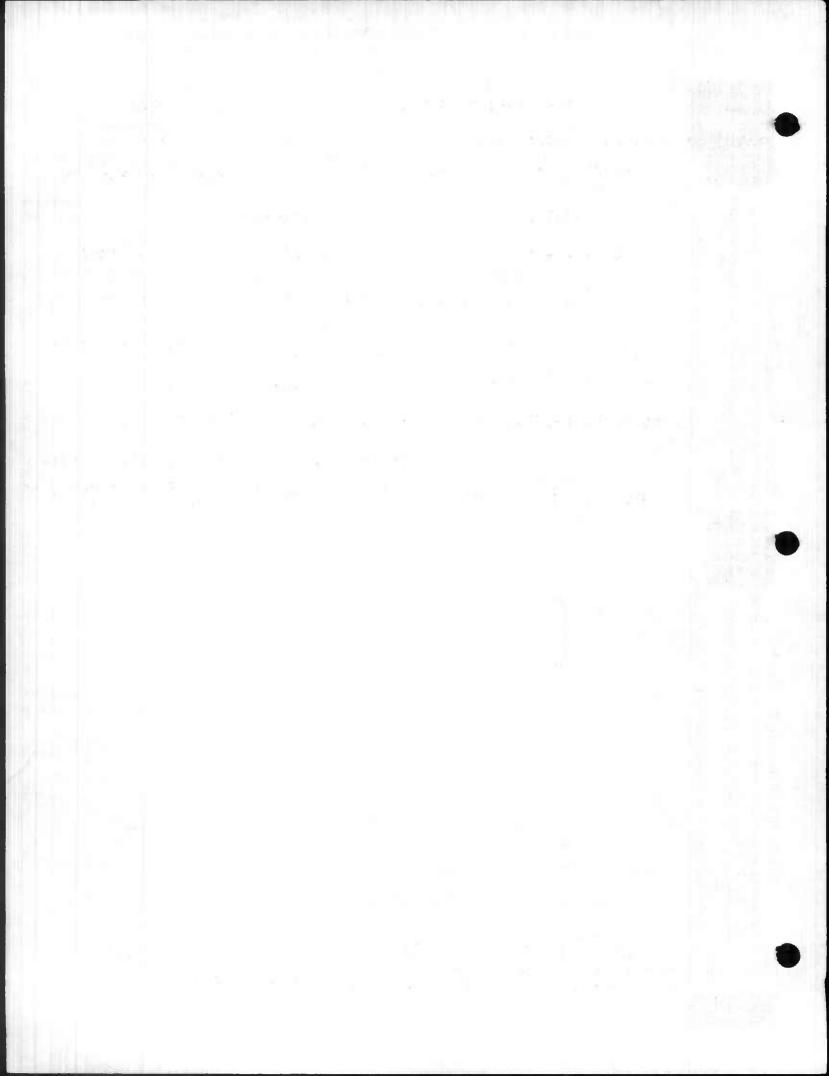
State of Maryland / Department of Health and Mental Hygiene () () () () () ()

	Certificate	of Death	Reg. No.	72400					
	Decedent's Name (First, Middle, Last)	2	. Date of Death	3. Time of Death					
Physician /Medical	Mary Catherine Norris	J	December 2, 20	00 10:45 AM					
Examiner	4a Facility Nama (ff not institution, giva street and number)	4b. City, Town, or Loca	tion of Death 4c. County of	t Death					
67	43265 St. John's Road	Hollywood	St. M	ary's					
Funeral	5. Social Security Number 6. Sex 7. Aga (fin yrs. last birthday) If Under 1	Year If Undar 24 Hrs. 8 Days Hours Min.	Data of Birth	9. Birthplaca (State or Foreign Country)					
Director	220-34-8599 1 M 2 F 94 Yrs. Months	Days Hours Min.	Data of Birth (Month, Day Year) August 19, 1906	Maryland					
2	Usual Residence of Decedant								
thouse the state of the state o	10a. State 10b. County 10c. City, Town or Location			10d. toside City Limits					
cto file of	Maryland St. Mary's Hollywood			1 ☐ Yes 2 ☒ No					
U site death with the Man/ler or frems 23s or 28s-f show miner must be notified at Funeral Director	10e. Street and Number 10f. Zip C		10g. Citizen of Wh						
th w		0636	U.S.A	•					
fier death v r fleme 23s	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 11. Was Decedent Ever in U.S. 11. Was Decedent Ever in U.S. 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent	nt ot Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric	fy Yas or No- can, etc.) 14. Race	- American Indian, Whita, atc.					
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72 hours natural;	15 Decedent's Education 16a Decedent's Usual	Occupation	16b. Kind of Busi	iness/Industry					
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d within glene.	8th Homemaker		Own Ho	ome					
	17. Father's Name (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surnama,)					
	John Lewis Abell, Sr.	Jane Lore	etta Wible						
arylic should and Men a marke numatic	19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural I	Route Number, City or Town, S	itate, Zip Code)					
Marity and 2 27 is 17 is	Elizabeth Jean Guy (Daughter) 43265 St. 3	John's Road, F	Hollywood, Mary	yland 20636					
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emit. Pages 1 ampartment of He									
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			dtown, Marylar	Approximate					
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Physician	(1) (1)	T		0201					
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Cartaly W	mary la	www.	· say					
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ei ed	b. Chronic Lym	phagorece	> Enorme	a you					
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ficate be expressed in the purish the purish edical E									
ficate be physicials is the bu	that initiated events resulting in death) Last Due to (or as a consequence of):								
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Box eath cert attendin Ifor usa									
at the death cer dby the attendir etached for usa	Part II. Other significant conditions contributing to death but not resulting in the underlying car	use given in Part I.	23b. Did tobacco use cont	tribute to the cause of death?					
Phys. Phys. Phys.			1 ☐ Yes 2 ₺ No	3 Probably 4 Unknow					
by bad by		- 1							
The law require tale has been single 2 should Completed	Congressive Beart +	To Dura	24a. Was an autopsy parformed?	24b. Were autopsy tindings available prior to					
Has be ge 2 sh	- Garre Jacon 1	COUNTY		completion of cause of death?					
The tare has page			1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No					
	25. Was case reterred to medical	26. Place of Death ((Check only one)						
	examiner? 1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO/	Other:	e 5 ⊠ Residence 6 □Other	(Specify)					
Physic residence of the Physics of t	27. Manner of Death 28a. Date of Injury 28b. Time of 28		d. Describe how injury occurre						
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DIVISION C be or Attending P is after death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could not be 28a, Place of Injury - At home, tarm, street, factory,	office 28	28f. Location (Street and Number or Rural Route Number,						
Direction of Line	4 Homicide building, etc. (Specify)		City or Town, State)						
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1	(40/1) (VI) (VI)	0041/	10	, ,,,					
M	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	11-11	1002C						
1/16	J. Patrick Jarboe, MD	HOLLYWOOD, M	aryland 20636						
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1							

On the continuous of the second second Comment your day of the trained with Chemistra Band Friday Throng . 7-5-51 (APP) U CABALLERY AR

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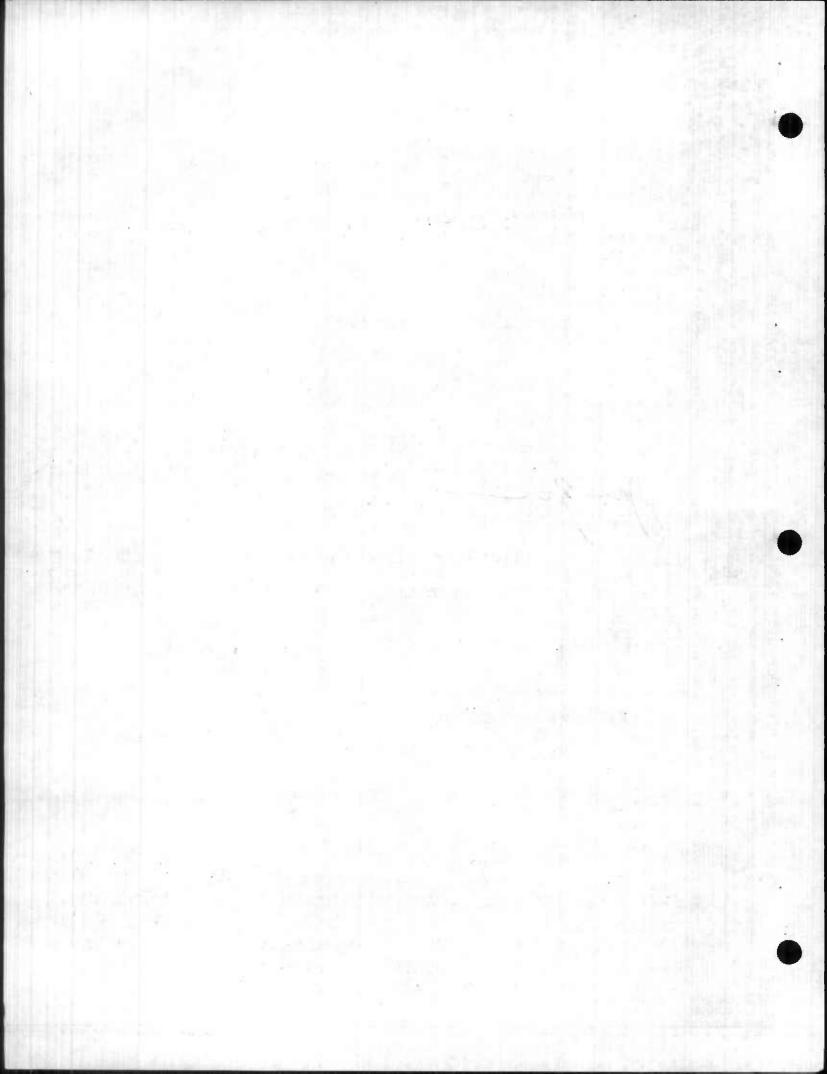


State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95

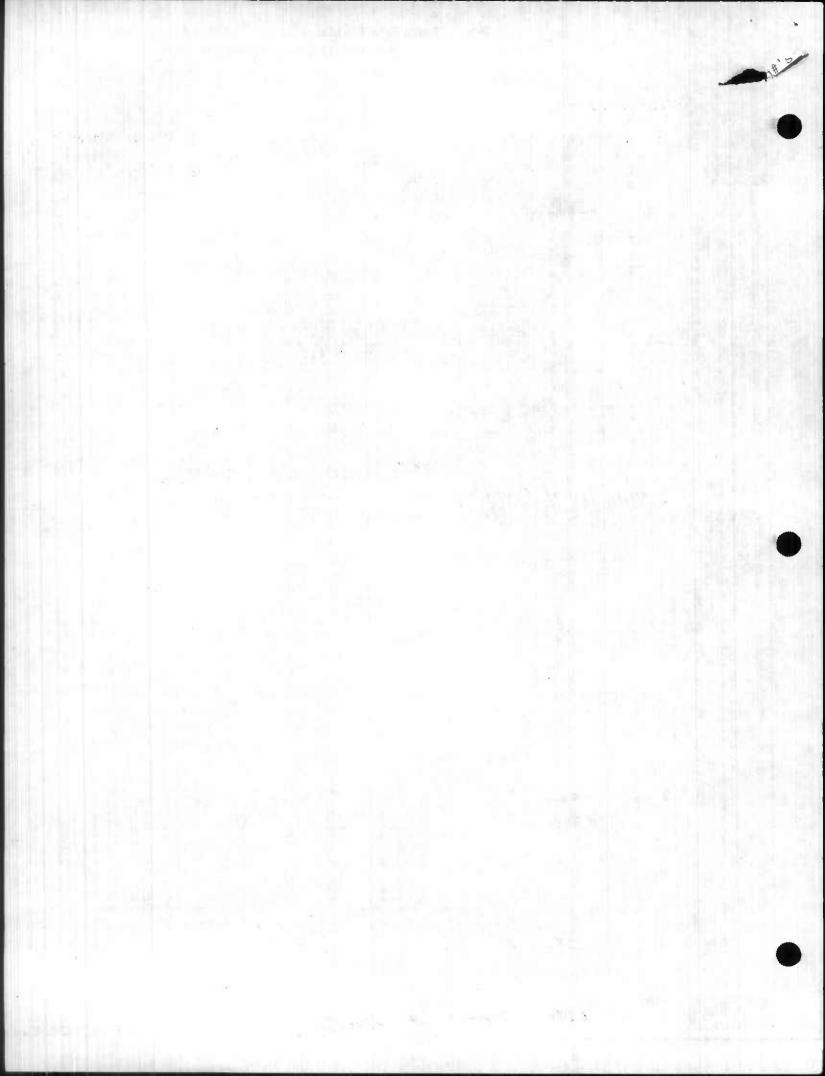


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State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Month Dec 18, Vaar Physician Helen Luckett Nelson 2000 8:00 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Nema (If not institution, give street and number) 4c. County of Death Examiner Prince George's Bradford Oaks Nursing Home Clinton If Undar 24 Hrs Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1 ■ M 2 TF Months 98 Director 577-22-2735 Aug. 8,1902 Washington DC the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits "natural", or items 23a or 28a-f ahow 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Camp Springs 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? With 5001 Dublin Drive 20746 U.S.A. Funeral 72 hours after death 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 No If Yas, Give X Year or Dates: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Stetus Bleck, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2 ☑ No Specify: White à 3 Widowed 4 □ Divorced Completed 16b. Kind of Businass/Industry traumatic avent, the Medical 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) d 2 should be filed within 72 th and Mental Hyglene. Elementery/Secondery (0-12) Collega (1-4or 5+) 12th N/A Clerk U.S. Government y maryland
y mark. Peges 1 and 2 should be filed.
Important: If Item 27 is marked any injury or other. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) William Henderdon Myrtle Shaw 19a. Interment's Name/Reletionship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Gloria Boertlein (Daughter) 5001 Dublin Drive Camp Springs, MD 20746 20b. Place of Disposition (Nama of camatary, cramatory or other place) December 22, 20a. Method of Disposition 20c. Location - City or Town, Stata *Surial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Barnabas Epis. Ch. Cem. 2000 Oxon Hill Maryland 22. Nama and Addrass ot Facility 21. Signature of Funeral Sarvice Licen Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton MD 20735 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or haen tailure. List only one cause on each line. Approximete Intarval Batween Onsat and Death Physician /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner to (eras a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that influed events.) nce of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated evants rasulting in death) Last Dua to (or as a consequence of): 88 for use as 987 signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to complation of causa of death? should I 24a. Was en autopsy performed? Completed page 2 s N/A director, page 1 ☐ Yas X☐ No 1 🗆 Yas 2□ No Physician: Be 25. Was casa referred to medical 26. Place of Death (Check only ona) Hospitel: Othar: 1 Yas 2 No. 10 1 Inpatiant 2 ER/Outpatient 3 DOA Nursing Homa 5 Residence 6 Other (Specify) this After this 28a. Data of Injury (Month, Day Year) 27 Manner of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Watural or Attending 5 Pending investigation 1 ☐ Yas 2 ☐ No after death. Director: / 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, tarm, street, factory, office building, atc. (Specify) 4 Homicide illed in To the Hospital within 24 hours To the Funeral E completely filled Hospital Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical (Check only one) 29b. Signeture and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 10 30. Name and eddrass of person who complated causa of death (Itam 23a) (Type, Print) Rene E. Grace, M.D. 9131 Piscataway Road, Clinton, Maryland 20735

State Registrar

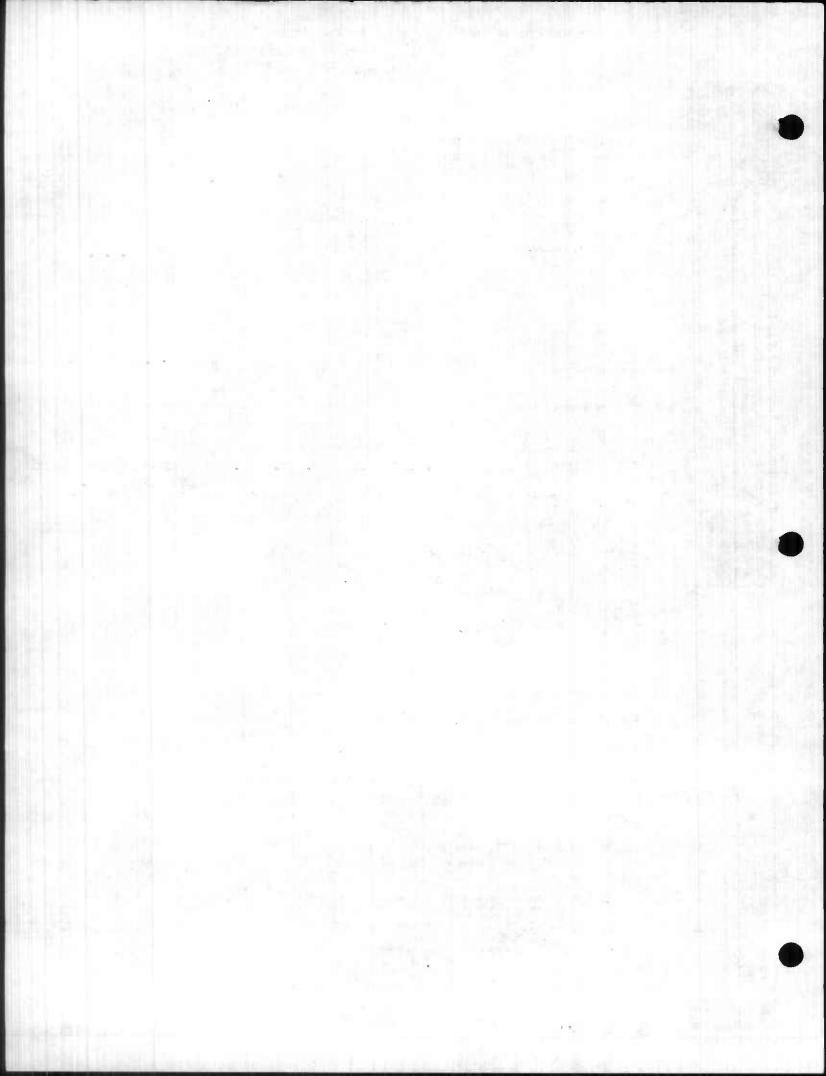
DHMH 16 Rev 6/95

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31. Data filed (Month, Day, Year)

32. Registrar's Signatura

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State Registrar

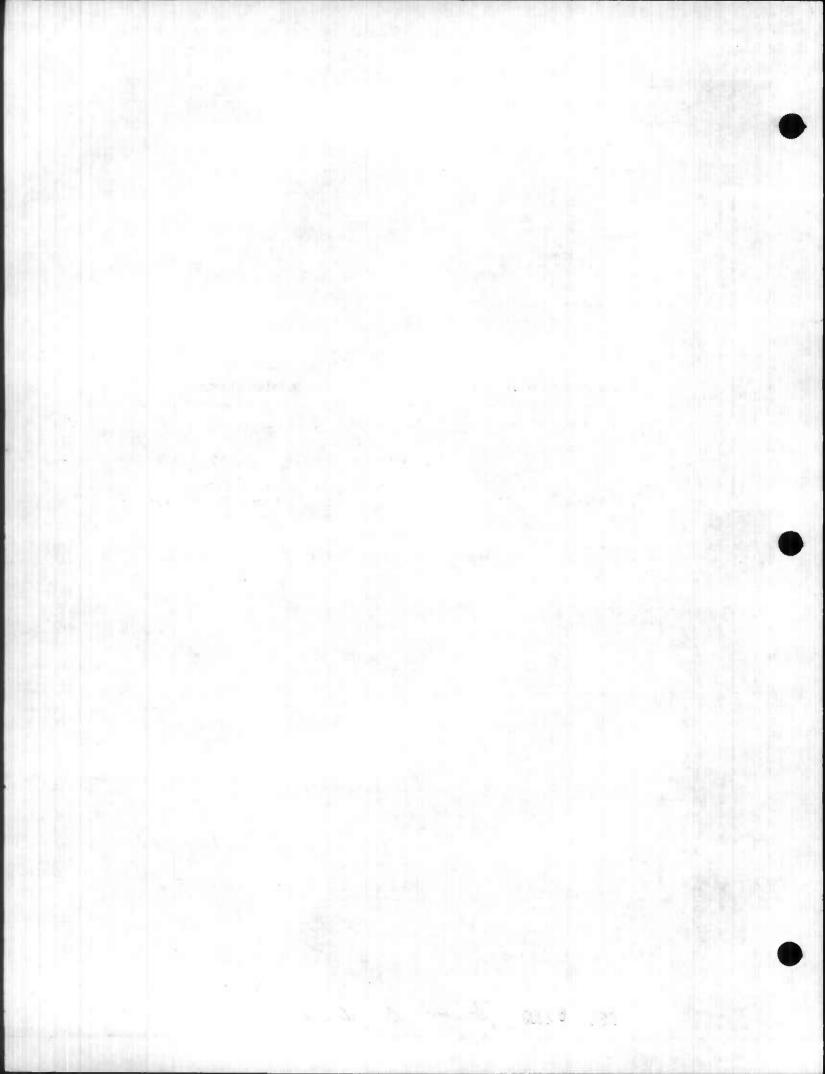
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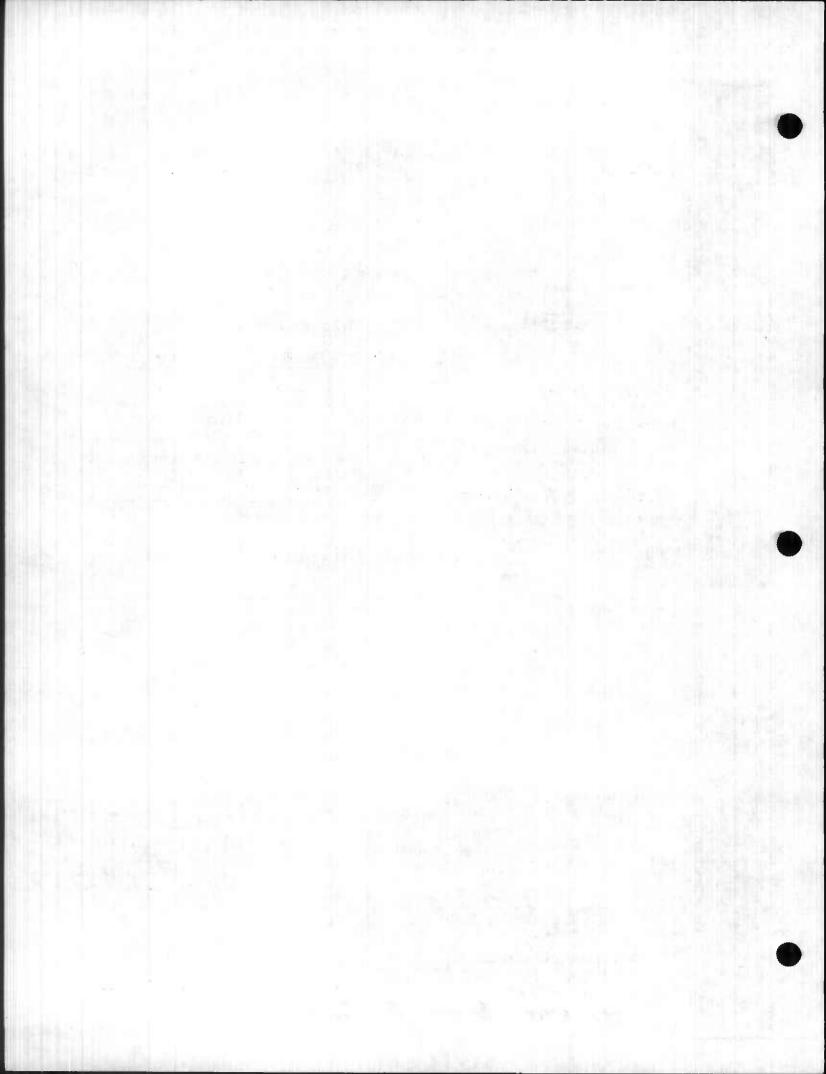
111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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	Lec	10e. Street and Number	ту 5	10f. Zip Coda						10	g. Citizen of W	/het Coun	ntry?
	a D	44620 St. Andre	206	519			U.S.A	۸.					
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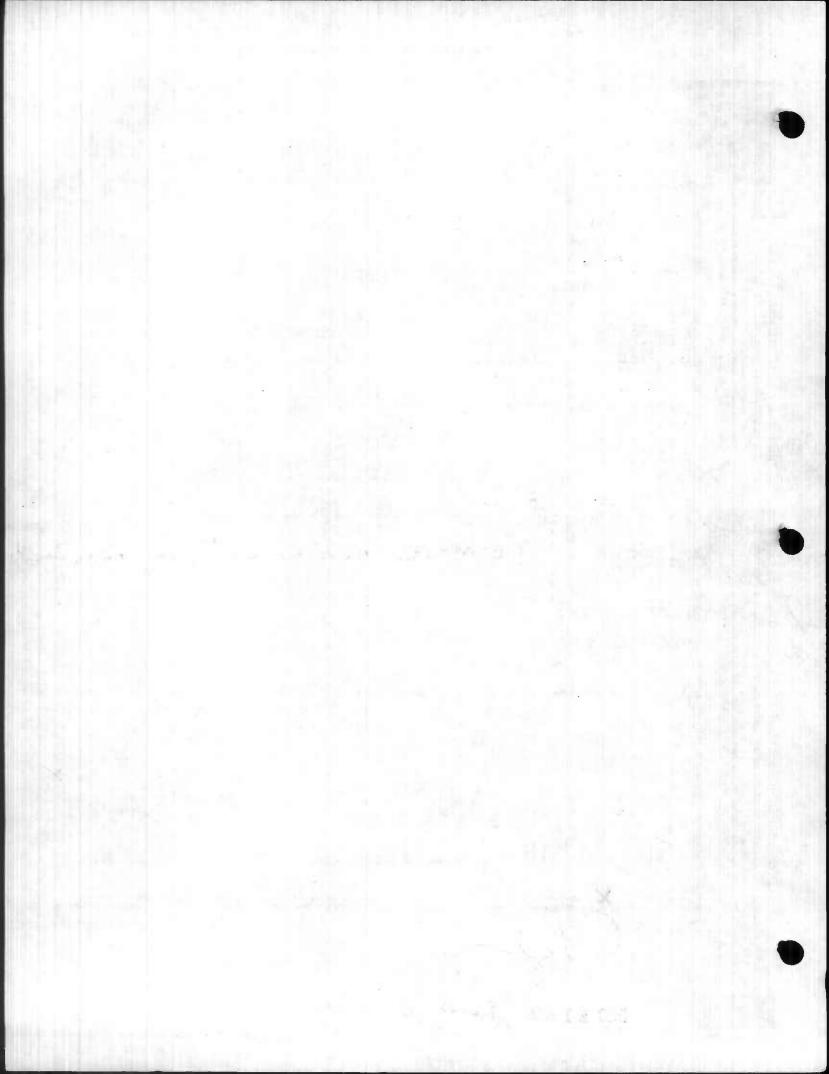
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Physician /Medical	DORIS A. OSBORN	DEC. 16, 200									
Examiner	4a Facility Name (If not institution, give street and number)		Location of Death 4c. County of MONTGO								
	SHADY GROVE ADVENTIST HOSE 5. Social Security Number 6. Sex 7. Age fin yrs.										
Funeral Director	010-14-6701 10M 2 TXF 84	Yrs. Months Days Hours Mir		Birthplace (State or Foreign V Country) NEW YORK							
* m	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Rockville										
i o	Md. Montgomery		X□ Yes 2□N								
ene. than 'natural', or items 23e or 28e-f show the Medical Examine must be notified at ompleted by Funeral Director	10e. Street and Number 9701- Veirs Drive	10f. Zip Code 20850	10g. Citizen of Wh USA	at Country?							
r tems 23s	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	,S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- 14. Race -	American Indian,							
'natural', or items 23e or 28e-f show idies! Examiner must be notified at eted by Funeral Director	1 Never Married 2 Married 1 1 Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		White, etc. White							
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ygiene. nor than "natur. n, tre Wedeal Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of we life. DO NOT use retired) Secretary		ailable							
Hygie Herring Co	17. Father's Name (First, Middle, Last)	-	ame (First, Middle, Maiden Surname)								
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if Health and Mental Hygiene. Nem 27 is marked other than other traumatic avant, tra Me To Be Compi	19a. Informant's Name/Relationship (Type, Print) Rev.Dr. Reichard-Executor	19b. Mailing Address (Street and Number or F 9701 - Veirs Dr.	, Rockville, Md	.20850							
int: If		Place of Disposition (Name of semetery, crematory or other place) tropolitan Cremato:	Date 20c. Location - Ci								
Department Important: Il any injury o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hysong Co., Inc									
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aw requires the second			24a. Was an autopsy performed?	24b. Were autopsy tindings available prior to completion of cause of death?							
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s certificate director, pag To Be Co	25. Was case referred to medical examiner?		eath (Check only one)								
울			Home 5 ☐ Residence 6 ☐ Other								
P P P	27. Manner ot Death 1 Naturat 5 □ Pending (Month, Day Year)	28b. Time of Injury M 28c. tnjury at Work?	28d. Describe how injury occurred								
at Director: After the in by the funers Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At he building, etc. (Specification of the building) of the country of the building of the country of the building of the country of the building of the country of the building of the country of the building of the country of the building of the country of the building of the build	ome, tarm, street, tactory, office	28f. Location (Street and Number City or Town, State)	cation (Street and Number or Rural Route Number, ly or Town, State)							
within 24 hours after deeth. To the Funeral Director: A completely filled in by the funeral Certification of the funeral Certification of the funeral Certification of the funeral Certification of the funeral Certification	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wiedge, death occurred at the time, date and plaction and/or investigation, in my opinion, death occ	ce, and due to the cause(s) end mann curred at the time, date and place, an	ner as stated. Indicate the description of the desc							
within To the	29b. Signature and title ot certifier	29c. License number	29d. Date signed	(Month, Day, Year)							
(6)	Millet lug	D39934	December	17,2000							
(5)	30. Name and address of person who completed cause of death (Item STEVEN To COVCTER, MD)	15201 Shady Grace Rd	\$202 Rockville M	10 20814							
	1	turo /									
State Registrar	31. Date tilled (Month, Ray, Year) DEC 2.2 2000 32. Registrar's Signa	G. Spark									

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 26 per verbal response by md G791 1/8/01 yf Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Year Physician 20, 2000 7:00 am Audrey Ruth Otto December /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Montgomery Hospice- Casey House Rockville Montgomery If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar 6 Sax Birthplaca (Stata or Foraign Country) **Funeral** 1 □ M 2 TF Months Days 69 Yrs. 326-26-4088 July 19,1931 Illinois Director Usual Rasidance of Decedan the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits than "naturel", or itema 23a or 28a-f ahow the Western Everyor must be notified at 1 Yas 2 No Directo Maryland Montgomery Kensington 10a. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20895 4212 Dresden Street USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ XNo If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 72 hours after 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 Yas 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) filed within 7 Hygiena. Elemantary/Secondary (0-12) Collage (1-4or 5+) 12 Homemaker Own Home 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) 2 should be f and Mental F la marked Arthur Lange Frances Pondelik 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Ia m any injury or other traun pace. Henry Fred Otto / Son 4212 Dresden Street, Kensington, MD 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Othar (Specify) Metropolitan Crematory 12/22/00 Alexnadria, VA 21. Signature of Syperal Service Lice 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** METATATIC Now small cellling /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Physician/Medical Examin ed by the attending physician and detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 12 Yee 2 No 3 Probably 4 Unknown signed t of Vitai Records, by The law requires 24b. Wara autopsy tindings available prior to been si 24a. Was an autopsy performed? Completed completion of ceusa of death? is certificate has director, page 2 a 1 Yas 2 No Physicien: 25. Was cesa rafarred to medicel axaminar? 26. Placa of Death (Check only ona) 8 Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 0 this funarai 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Mannar of Death 28b. Tima of 28c. Injury at Work? After t Division Attending 1 Naturat 5 Panding invastigation death. 1 Yas 2 No To the Hospital or Attenditional within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Phyeician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. edical 29a. Certifian (Check only one) 29b. Signatura and titla of certifia 29c. Licensa number 29d. Data signed (Month, Day, Year) 305 D 35635 December 20, 2000 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) MD 18111 Joseph Kaplan, Prince Philip Drive, Olney, MD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State socks Paren DEC 2 1 2000 Registra **DHMH 16 Rev 6/95 ORIGINAL**



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				Cei	rtificate o	f Death		Reg. No.			
		1. Decedent's Name (First, Midd	ile, Last)						3. Tima of Death		
	Physician	Frances	Uampton		Dogg		Month		Yaer		
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4	Examiner	and seem and introduced									
			ursing Center		It Under 1 Ve	Leona	rdtown	St.	Mary's		
	Funeral	5. Social Security Number 578-22-9016	6. Sex 7. Age (In yrs.		If Under 1 Ye Months Day	ys Hours	24 Hrs. 8. Date of Bir Min. (Month, De	by, Year)	9. Birthplece (Stete or Foreign County) ashington,		
	Director		86	Yrs.			Februar	y 15, 191	14 washington,		
	2 .	Usuel Residence of Decedent	100 Ci	ty, Town or Lo	tion				and maids Other Limites		
	the state -	10a. State 10b. County	/ TOC. CR	ty, Town of Lo	cation				10d. tnside City Limits		
	n the Maryla r 28a-f show anotified at frector	Maryland	St. Mary's	Leonar	dtown				1 □ Yas 2 및 No		
	or 28a-fr	10e. Street and Number			10f. Zip Code	a	7-11-1-1	10g. Citizen of Wh	nat Country?		
	25a or Lat be r	2211 Cedar Lar	ne Apt.			20650		II	S A		
	deat deat	11. Merital Status	12. Was Decedent Evar in U	,S. 13.			gin? (Specify Yas or No., Puarto Rican, atc.)		- American Indien,		
-	F. Spe	1 Never Merried 2 Mai	Armed Forcas?				, Puarto Hican, atc.)	Bleck,	, White, etc.		
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三	and and a	21. Biothy Funery Styles	Conses	- 32	2. Name and Ad	dress of Fecilit	ral Home,	D. A			
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	-	shock, or heart failure. Lis	or complications that caused the deel it only one ceuse on each line.	th. Do not en	ter the mode of o	dying, such es	cardiac or raspiretory e	errest,	Approximate Interval Batween		
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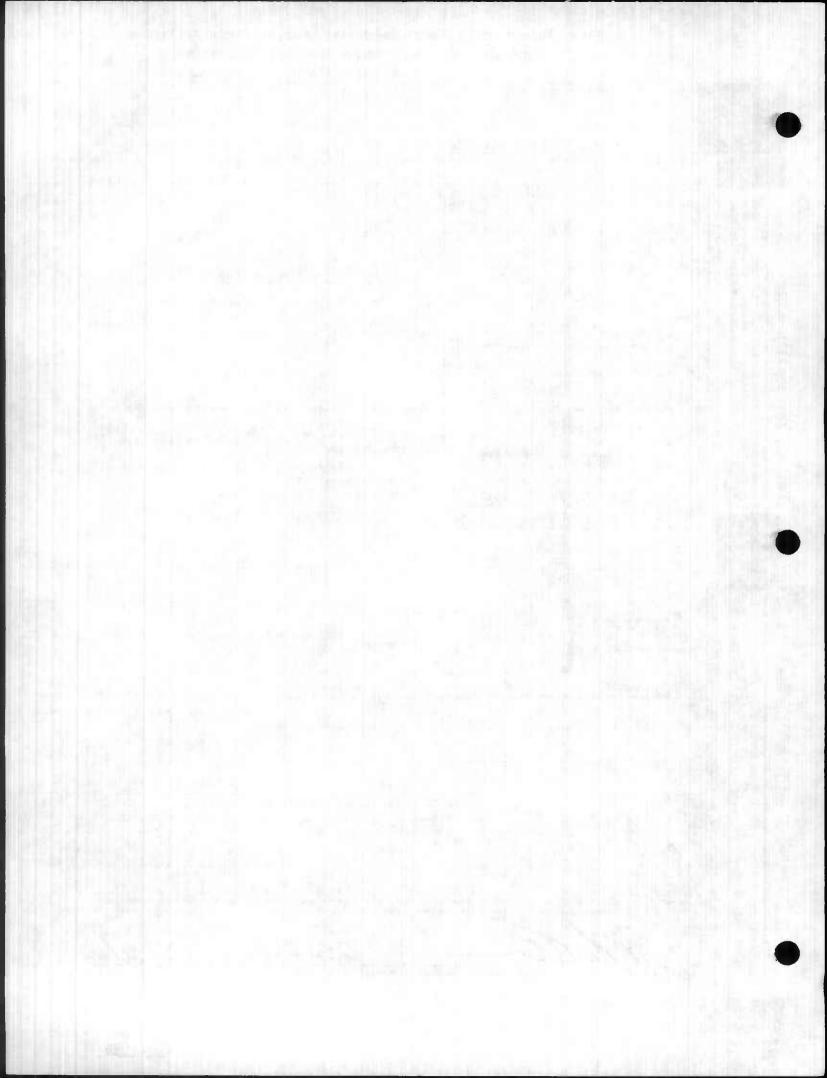
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State of Maryland / Department of Health and Mental Hygiene

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	5. Social Security Number 6. S		Age (In yrs. las		-	r 1 Year	If Under		8 Date of Bir		oline	nlece (State	or Foreign
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important: If item 27 is marked otiver than "natural", or items 23s or 25s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Merried 2 Married 3 Widowed 4 Divorced	If Yes, Give	1 Yes 2 No If Yes, Give Yeer or Detes:			1 ☐ Yes 2 ☒ No Specify:				Speci B1a	fy: ack		
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	17. Father's Neme (First, Middle, Last)						18. Mothe	er's Nem	e (First, Middle	, Maiden Sume	me)		
	Guy Garf	ield Pa	tterson					Leor	na Blad	ck			
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	Miles Patterson 20e. Method of Disposition		20h Pled	e of Dispos			Aven	ue,	Apt. Z	20c. Location			2160.
	12 Burial 2 Cremetion 3	Removal from St	COR	netery, crem	etory or	other plea	ce)	1	Dere	200. Location	- City of Ti	OWII, Stele	
	4 ☐ Donetion 5 ☐ Other (Specify	1)	Unio	n Chu	rch	Ceme	tery	11	2/29/0	Green	sbor	o, Mar	yland
	21. Signature of Funeral Service Licenses 22. Name end Address of Fecility												
	Moore Funeral Home, P.A.												
	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, approximate shock, or heart feiture. List only one ceuse on each line.												
	shock, or heart feiture. List only one cause on each line.												
	Immediate Ceuse (Finel												
	Immediate Ceuse (Finel disease or condition metastatic prostatic carcinoma												ears
	resulting in deeth)	0.	Due to (or e									1	
9													
Examiner		b											
170	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		Due to (or e	s e consequ	Jence of):	194							
	Cause (Disease or Injury	C											
	resulting in death) Lest		Due to (or e	s e consequ	enca of):								
		d											
	Pert II. Other significant conditions co	contributing to deeth but not resulting in the underlying cause given in Pert I.						23b. Did	23b. Did tobacco use contribute to the cause of death?				
ruysician									10	Yes 2 No	3 Pro	obably 4	Unknown
						1-11			24a. Was	en eutopsy	24b. W	/ere autopsy	findings
no solding									hed	ormed?	ev ev	veilable prior ompletion of	to
1											of	f death?	
									10	Yes 2 No	1	☐ Yes 2☐	No
	25. Wes case referred to medical						26. Plece	e of Dee	th (Check only	one)			
	examiner?	Hospitel:	patient 2 EF	3/Outnatient	3 D	OA Oth	or /			idenca 6 🗆 O	ther /Sneci	ifu)	
To To	27. Menner of Deeth	28e. Dete of	Injury 2	8b. Time of		28c. Injur Wor				how injury occu			
Ilor	1 Naturel 5 Pending	(Month,	Dey Year)	Injury				No					
Certification:	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No						Opt Leasting	(Canada and Muse	- h D	at Davida Atua	
듣	4 ☐ Homicide determined	28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number of Rurel Route Number or Route Number or Route Numb								noer,			
3			Delta o			L Qu		1					
edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	iner: On the basi	s of examination	edge, deeth n and/or inve	occurred estigation	et the tir , In my o	me, date en pinion, des	nd place, oth occur	end due to the red at the time,	cause(s) and n date end place	nenner as : , end due i	stated. to the cause(s)
N N	29b. Signeture and this of certain	end menne	Meleu.		20	c Licens	e number			29d. Date sign	ad (Month	Day Year)	
	Los. Signotularity	111			23	Z LICOIIS	> (181		Lou. Date sign	/ worth,	Joy, (bai)	
	y la nucl	N-	_			03	210	104		121	261	a	
	39. Name and admess of person who o	completed cause	of deeth (Item 2	3a) (Type, P	Print)					1		THE LET	
	Section of the sectio					ITNIC	ית ביו	CIT	127 C	ON ME	210	501	
	dr ANDREA ALLI 31. Dete filed (Month, Dey, Year)			S.	ICAN	TING	TON	ST.	EAST	ON, MI	216	301	
State	DEC 9 17 2000	32. Heg	istrer's Signatur	Ano	· Va	,							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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				-			

	Physician	1. Decedent's Name	(First, Middle, La	ast)			Timodio o		2. Date of De Month	Day	Year	3. Time of Death	
100	/Medical	Jean Peri				Decembe	2000 2		2000 P				
4	Examiner	4e Facility Name (If I			ımbər)		4b. City, Town, or L	ocation of Deell					
	ð	1851 Blue						Elkton		Ceci			
н	Funeral	5. Social Security Nu		Sex 1 □ M 2 ☑ F		. last birthdey)	Months Day		8. Date of Bir (Month, Da	th ly, Year)	9. Birthp Coun	lace (State or Foreign try)	
	Director	221-30-0	225		55	Yrs.			FEB 13	, 1945	Dela	ware	
	pue »	Usual Residence of I	10b. County		10c. C	ity, Town or Lo	cation				10	0d. Inside City Limits	
	leho or				7 1 1 1 1 1 1							1 ☐ Yes 2 ☑ No	
	permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or terms 23s or 28s-4 show any injury or other traumatic event, the Medical Event ment be notified and page. To Be Completed by Funeral Director	Maryland Cecil Elkton 101. Zip Code								10g. Citizen of	Mhat Caus	12	
	with De or												
	eral	1851 Blue	e Ball R		sedent Ever in	110 12	2192		posity Voc or No	United	Stat a - Americ		
	iter d	11. Maritel Stalus 1 ☐ Never Marrie	d 253 Marriad	Armed F	orces?	0,3.	If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	Bia	ck, White,		
20	alf, or	3 Widowed 4		1 Tes If Yes, Gi Year or I	ive		1 ☐ Yes 2 🔀 N	o Specify:		Specif	whi	te	
21215-0020	2 hou		15. Decedent's E			16a. Dece	dent's Usual Occ	upation		16b. Kind of B	usiness/Inc	Justry	
215	ed within 72 holygiene. Nor than "naturality the transcellar. Completed	(Specifical Elementary/Second	ly only highest gr		(1-4or 5+)	(Give	kind of work don DO NOT use reti	e during most of work red)	ring				
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p	d other overit,	17. Father's Name (F	irst, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Sumer	ne)		
lar	Menta Menta	Darlingt	on Knott	s				Dorothy	Finica	1			
Maryland	should had a	19a. Informant's Nar	me/Reletionship	(Type, Print)		19b. Maili	ng Address (Stre	et and Number or Rui	ral Route Numb	er, City or Town	, State, Zip	Code)	
Σ	aith e	Herschel	Perment	ter/Hus	band	1851	Blue Ba	11 Road, E	Elkton,	Marylan	d 219	921	
re	of He othe	20a. Method of Dispo		17		Place of Dispo	sition (Name of metory or other p	lece)	Date	20c. Location	- City or To	wn, State	
Baltimore,	Pege ient c iry or	1 LA Burial 2 L. 4 Donation 5	Cremation 3 [5 Other (Special		State	erry Hi	11 Meth	042 04	2/26/00		y Hil	.1,	
alti	mit.	21. Signature of Fun	gral Sarvice Lice	nsee	/		2. Name and Add	ress of Facility		- Harys	.and		
m	Deperiment of the population o	1	10	ale	11-1			for Funerackton Stre			vland	21921	
		23a Part Enter the	e disease, or com	plications that	caused the dea			ying, such as cardiac			,	Approximete	
	Physician	shock, or heart	failure. List only								1	Onset and Death	
	/Medical	Immediate Cause (F		Rh	numa	torid 1	Arthri	tion			1	years	
	Examiner	resulting in death)		a		(or as a consec						0,000	
_		CALL CALL					NE PERSON						
	n certificate be executed inding physician and use as the buriel-trensit in/Medical Examiner	Sequentially list conditions if any, leading to imm	ditions,	Due to (or as a consequence of):									
oʻ	lan e	if any, leading to immoduse. Enter Underlocause (Disease or Inthat initiated events	mediate lying										
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S	signed bed by							E TOTAL	-		Oak W		
Record	The lew require sate has been signed 2 should Completed	ME CONT								an autopsy omied?	av	ere autopsy findings ailable prior to mptetion of cause	
ec	nas b			7	144,114	4						death?	
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5	hysic his ce al dire	1 Yes 2 N	lo			☐ ER/Outpatie	1 3LI DOA	Other: 4 Nursing He		idence 6 DOt		y)	
Division of Vital	ther the uners	27. Manner of Death	5 Pending		of Injury nth, Day Year)	28b. Time o	W		28d. Describe	how injury occu	rred		
Sic	Attending or deeth. •ctor: After by the fune fiffcation	2 Accident	Investigatio					Yes 2 No					
\geq	us or Attending P rs after deeth. el Director: Attert led in by the funera Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)						a	City or To	wn, State)	ber or Hure	il Route Number,	
	Urs a Urs a Co		<i></i>										
	n 24 hou n 24 hou ne Fune pletely fil	(Check only 2	1☑ Certifying Pt	miner: On the b	pasis of examin	owledge, deat ation and/or in	n occurred at the vestigation, in my	time, date end pleca, opinion, death occur	and due to the red at the time,	date and place,	anner es s , and due to	tated. the cause(s)	
	To the Hospital or Attending Physician within 24 hours after deeth. To the Furneral Director: After this completely filled in by the funeral director and Medical Certification: To Medical Certification: To	29b. Signeture and ti	itle of ortillor	and mer	nner stated.		20c Line	nse number		29d Date sign	ad (Month	Day Year)	
	F. 3 L 8	250. Signeture and th	Ka 1	0.0	MIN		200. 6100	29c. License number			29d. Date signed (Month, Day, Year)		
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	6	30. Neme and address	ss of person who	completed cau	1100	m 23a) (Type,	Print)	3B, ER	Eta 1	10010	21		
	State	31. Date filed (Month	Day Year)	32 5	Registrar's Sign		of scule	010,00	CON	0217	-/.		
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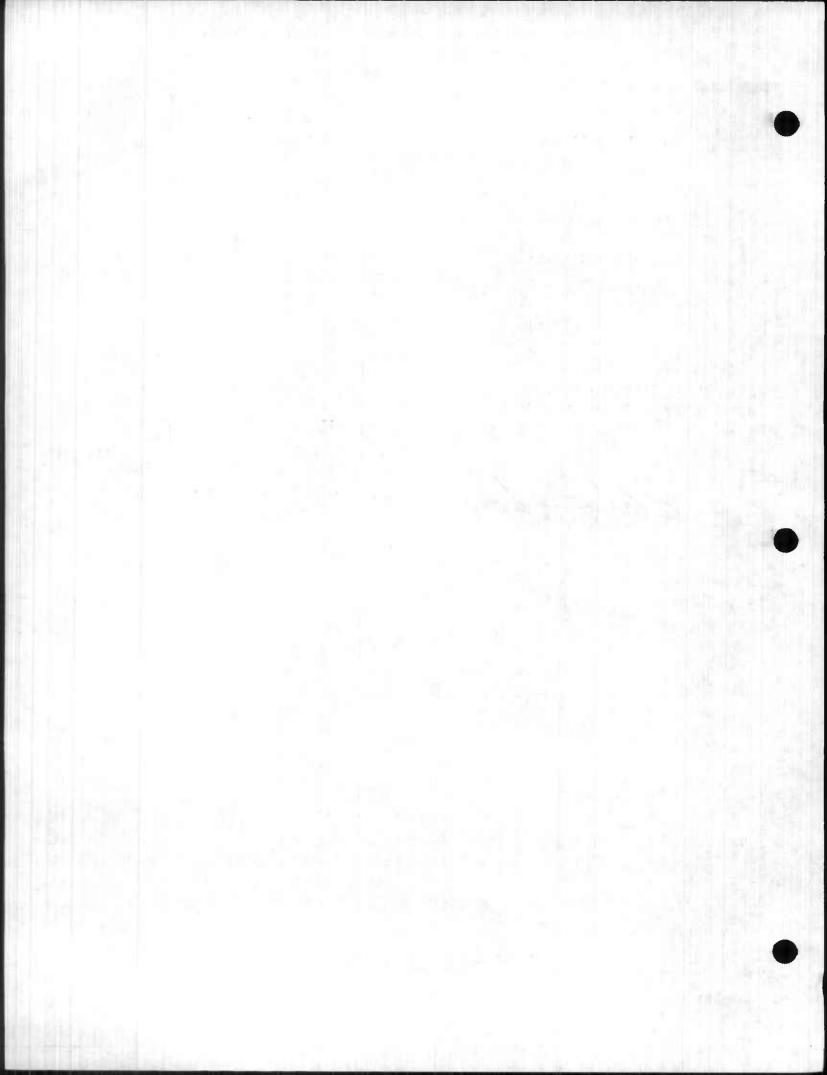
State

Registrar

DEC 2 6 2000

Sporks

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Month **Physician** December 14, 0335 Pulley 2000 Rertha Celest /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot The Memorial Hospital Easton 5. Social Security Number If Under 1 Yaer 8. Data of Birth (Month, Dey, Year) Nov. 22,1926 7. Aga (In vrs. last birthday) If Under 24 Hrs Birthplace (Stata or Foreign Country) Funeral Months Deys Hours 1 M 25 F 74 Director 217-22-2440 Maryland Usual Rasidence of Decedent 10e. Stata 10b. County 10c. City. Town or Location 10d Inside City Limits Herre 23e or 28e-f show free must be notified at 1 ☐ Yas 2 No Director Maryland Queen Annes Grasonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Road 21638 USA Forest Funeral 12. Wes Decedant Ever In U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indien, Bleck, White, etc. 1 Nevar Married 2 Married Maryland 21215-0036 "natural", or 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Black. Pulley Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Private Nursing Hyglene. Giver Hospice Care 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Surnama) Be 1 and 2 should be Mental Bertha marked White Pulley Queenie William m al / 19e. Informent's Name/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) or other tra P.O.Box 203, Grasonville, Maryland 21638 Pulley /son Bruce Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete Pages 70 1 ■ Buriel 2 □ Crametion 3 □ Ramoval from State Separtment mportant: If Union Wesley Church Cem. 12/20/2000 Chester, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fungual Strvice Licensee 22. Neme end Address of Fecility Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 23a. Part1. Enter the disease, or complications that causad the death. Do not antar tha mode of dying, such es cardiec or respiretory arrest, shock, or haert failure. List only one ceuse on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immedieta Causa (Final disaese or condition resulting in death) W Examiner Due to (or es e consequence of): Examine 400al that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that injury Due to (or es e consequende of): Division of Vital Records, P.O. Box 68760, Physician/Medical thet initieted events resulting in death) Last Due to (or es e consequence of): attending p Se 23b. Did tobacco use contribute to the cause of death? Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. the signed by t 1 Yee 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to complation of cause of deeth? been si 24a. Was en eutopsy performed? Completed page 2 has ils certificate h 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only ona) Hospitel: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this After this 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending 1- Neturel death. n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fi 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner es steled.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner steled. 29a. Certifier edical (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signeture and little of conflier 29c. License number Tu

State Registra

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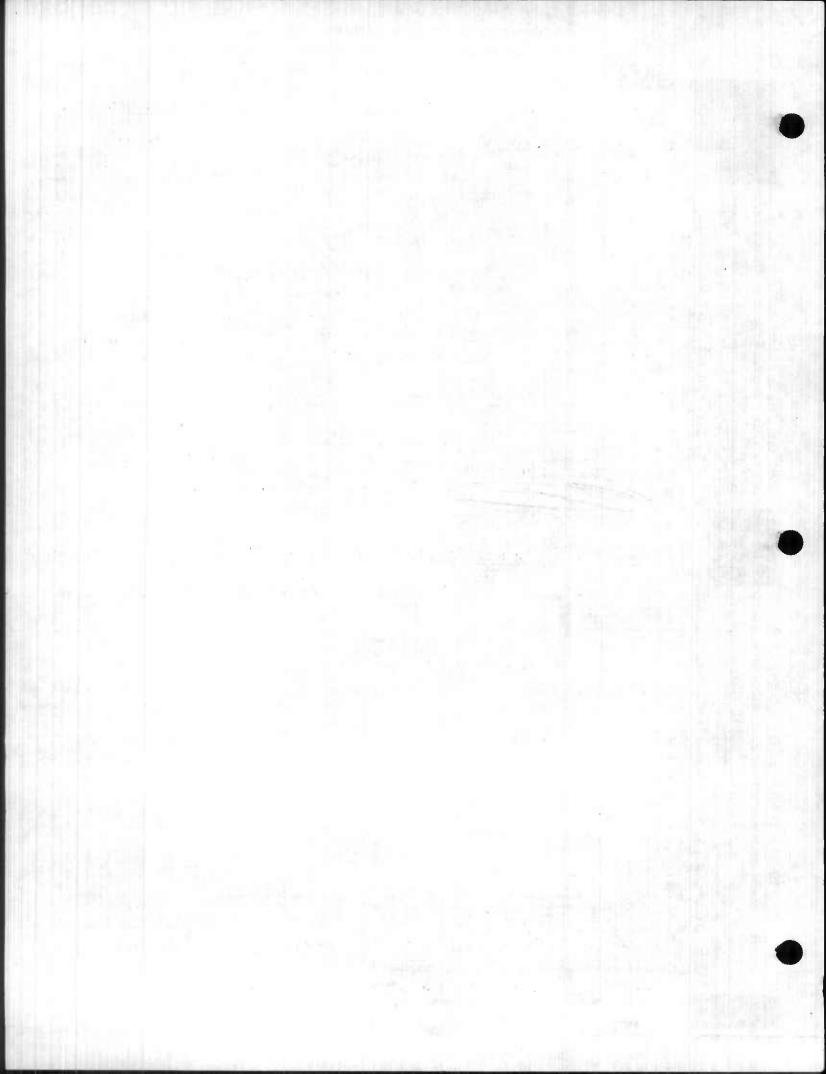
31. Date filed (Month, Day, Year)

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signatura

ORIGINAL

Jeaninne Einfalt, D O , Memorial Hospital, 219 S. Washington St., Easton, Md. 21601



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Deta of Death 3. Tima of Death Dey **Physician** ROBERT 1845 GEORGE POHLMANN DECEMBER 19 2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Nama (If not institution, giva street end number) Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER 8. Date of Birth (Month, Dey, Year) If Under 1 Year If Undar 24 Hrs. Birthplace (Steta or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□ F Yrs. 69 Director 579-38-7004 WASHINGTON, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 28a-f show 1 Yes 2 No Directo MARYLAND WICOMICO **PARSONSBURG** 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? free man be n 8116 PINTAIL DR U.S.A. 21849 Funeral 12. Wes Dacedant Evar in U.S. Armed Forces? NATA 13. Wes Decadent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Stetus Armed Forces? NAVY
1 M Yes 2 □ No
If Yes, Give
Yeer or Detes1 951-1955 1 ☐ Never Merried 2 【 Married 8 1 Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. ELECTRONIC SPECIALIST U.S. GOVERNMENT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Pages 1 and 2 should be nent of Heelth and Mental ROBERT GEORGE POHLMANN, SR. GRACE EVELYN HUNT 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 If item 27 l MARY JANE POHLMANN 8116 PINTAIL DR. PARSONSBURG, MD 21849 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Depertment 4 Donetion 5 Dother (Specifyentombment) WICOMICO MEMORIAL PARK 12/22/00 SALISBURY, MARYLAND 21. Signature of Funeral Servica Licansee 22. Neme end Address of Fecility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 Approximete fnterval Between Onset end Death 23a. Pert1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Physician Immediate Cause (Final disaase or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Examine Sequentially list conditions, if eny, leeding to immadiata cause. Enter Underlying Cause (Disaase or injury thet initiated events rasulting in deeth) Last Due to (or es e consequence of) Physician/Medical Dua to (or as e consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 3 þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Was en eutopsy performed? Be Completed 2× No page 1 Yes 1 Yas 2 No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Rasidence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending Injury 1 PNaturel 1 Yas 2 No death. 2 Accident invastigation Director 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 G-Cortifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated.

Vital Records, of Division

ASH MAGO

ROBINT

To the Hospital
within 24 hours of
To the Funeral C MIVA

Da State

Registrar

29b. Signature and title of cartiful

29c. Licansa numbar

29d. Date signed (Month, Dey, Year)

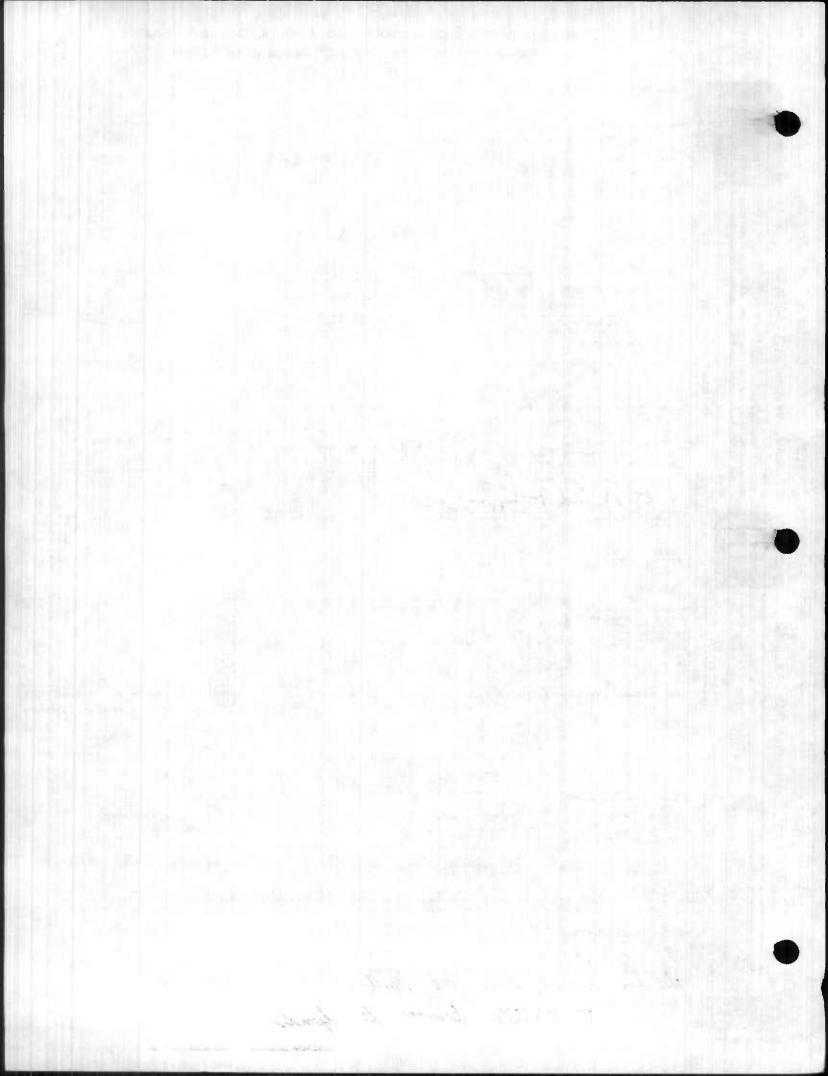
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) KobINS, WILLIAM M. D.

1109

31. Dete filed (Month, Dey, Yeer)

29a. Certifier (Check only one)

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. #4b, 12-20 State of Maryland / Department of Health and Mental Hygiene
Amended #10C/12-20-2000/WCHD/MAP Certificate of Death
Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Marion O. Perry Dec 17 2000 4:15 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Hebron 4c. County of Deeth 6743 Whetstone Drive Wicomico If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Dey, Yea Feb 17, 1 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country)
 MD Deys 1X M 2□ F 218-30-1476 64 Yrs. Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 ➡ No Wicomico - Salisbury Hebron 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 6743 Whetstone Drive 21801 U.S. 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Cosmetology 7th Business Owner 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Daniel Perry Daisy Mae Nutter 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joyce McClees Perry/wife 6743 Whetstone Drive, Hebron, MD 21830 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Remove from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Green Acres Mem Park 12/23/00 Salisbury, MD 21. Signeture of Funerel Service Common 22. Name end Address of Fecility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Betw Onset end Deeth Immediate Cause (Finel disease or condition resulting In deeth) Colon Conse Metagtatia 3 years Sequentially list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ HomicIde 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29a. Certifier (Check only one)

P.O. Records, of Vital To the Hospital or Attanding Physician: within 24 hours after daeth.

To the Funeral Director: After this certifica completely filled in by tha funaral director; to Division

M D

State Registrar

Physician

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Examiner

Director

Funeral

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Completed

Funeral

Director

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daeth

72 hours efter

permit. Pages 1 and 2 should be filed within.
Department of Heelth and Mental Hygiena.
Important: If Item 27 is marked other than 'n any injury or other traumatic account.

Physician /Medical

Examiner

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attending for use as

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certificate

signed b

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Physician/Medical

by

Completed

Be

2

Certification:

Medical

29b. Significant und Little of cartifier

James E. Martin 31. Dete filed (Month, Day, Year) 2000

be axecuted

Box 68760,

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23a or 28a-f show traumetic event, tra Medical Examinar rivist be notified at

m.O., 145 E. Carroll St., 5-1:560, MD. 32. Registrer's Signature

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

M. O.

29c. License number

030690

29d. Date signed (Month, Dey, Year)

Dec. 19, 2000



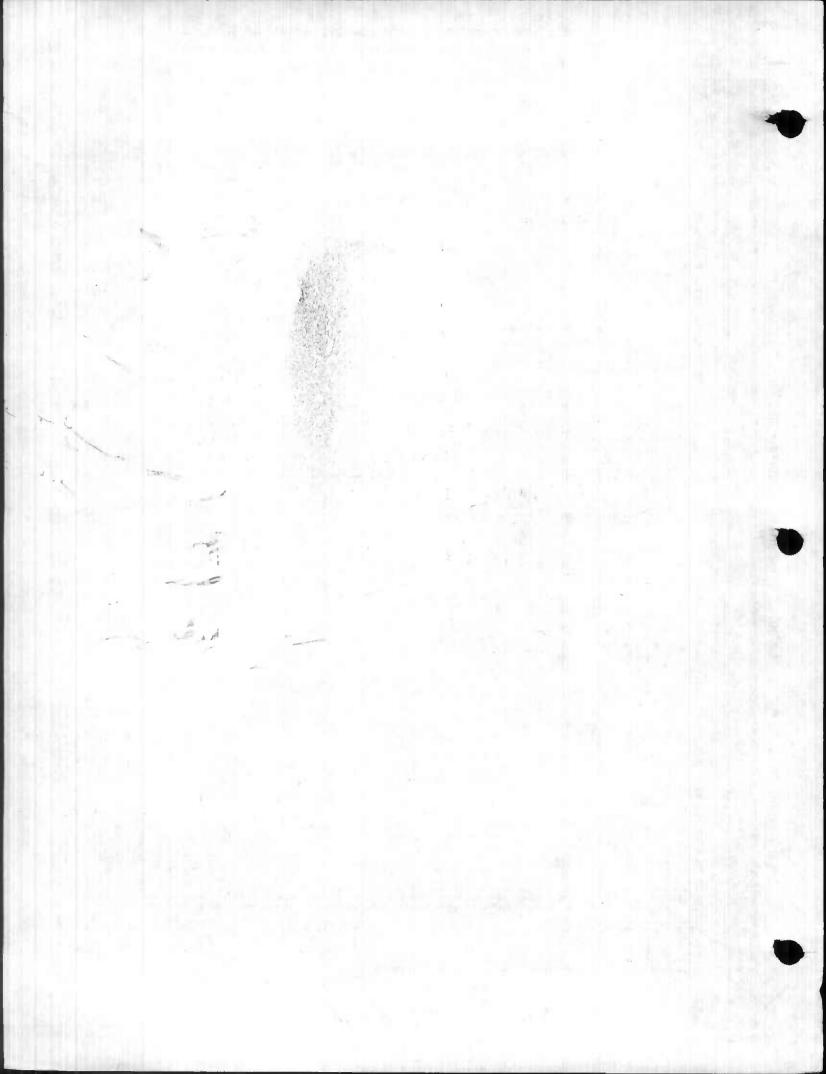
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Registra

31. Dete filed (Month, Day, Year)

32. Registreds Signatura

DEC 27 2000 D



filed within 72 hours after Baltimore. Maryland 21215-0036 the Medical Hygiene. is 1 and 2 should be filed vir Health end Mental Hygie Itam 27 is marked other to other treumatic event, in of Health permit. Pages 1 Department of H Important: If its any Injury or ott page.

> **Physician** /Medical Examiner

certificate be executed physicien and s the buriel-transi Box 68760. 88 esn 0 ed by the a P.O. signed b Records. page 2 s has certificate Division of Vital Physician: director this funeral After Attending s after death. 3 6

Prince George's Birthplace (State or Foreign Country) Washington, 10d. Inside City Limits 1 XYes 2 ☐ No 10g. Citizen of What Country? S. A. 14. Race - American Indien, Black, White, etc. Specify: Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Net Working Supervisor Private 12th 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Roxie Woodland 2 Leon Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Juanita E. Pray / Wife 6035 Naval Avenue Lanham, MD 20706 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park 12-26-00 Landover, MD 5 Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Rd Landover, MD 20785 THI 23a. Pert/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finel MULTIPLE INJURIES AND STAB WOUNDS disease or condition resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that intilated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was en autopsy Completed 1X Yes 2□ No 1 Yes 2□ No 25. Was case referred to medicel examiner? 26. Place of Deeth (Check only one) Be 1⊠ Yes 2□ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) at scene 2 27. Menner of Death 29d. Describe how injury occurred subject jumped from highway overpass aster stabbing himself 28c. Injury at Work? 28a. Date of injury (Month, Dey Year) 28b. Time of Certification: 5 Pending investigation 1 Natural 12/20/00 1 ☐ Yes 2 ☐ No M 2:33 2 Accident 6 Could not be determined 3KI Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Jown Stete) Central Avenue-West under 1495, Prince George's Co., Md. 4 Homicide roadway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical (Check only onel

3. Time of Death

2:45 A.M.

29d. Date signed (Month, Dey, Year)

December 20, 2000

State Registrar

Stephen S.
31. Date filled (Month, Dey, Year) DEC 2 6 2000

29b. Signature and title of certifie

Raduntz 32. Registrar's Signature

30. Name end address of person who completed ceuse of death (flem 23a) (Type, Print)

ORIGINAL

MIL

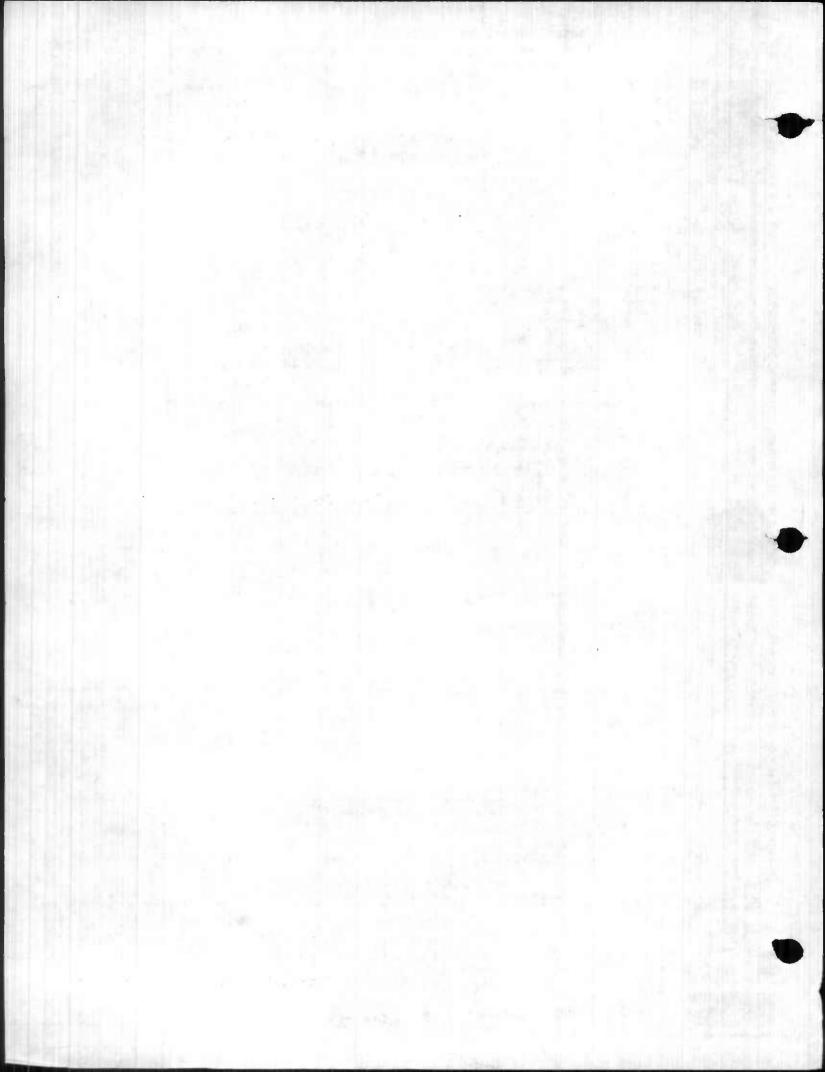
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

Hospital 24 hours

To the Hosp within 24 ho To the Fune completely fi



DHMH 16 Rev 6/95

ORIGINAL

